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INDEPENDENT INVESTIGATION

University Hospital Limerick

Aoife Johnston

Investigator: Mr. Frank Clarke

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CHAPTER 1 - INTRODUCTION

I was appointed by the CEO of the HSE to act as an Independent Investigator into matters connected with the tragic death of Aoife Johnston at University Hospital Limerick ("UHL" or "the hospital"). That appointment was confirmed in a letter of 6th January 2024 from Philip Lee Solicitors on behalf of the CEO, which letter also indicated that the Investigation was to be carried out in accordance with the Terms of Reference which were enclosed with same. A copy of those Terms of Reference is annexed as **Appendix 1** to this Report.

I commenced work on the Investigation on Monday January 8th 2024.

While there are a number of observations in relation to Inquiries and Investigations generally set out in Chapter 10, it is important to note that this Investigation was neither statutory nor on foot of an existing and agreed framework. It follows that the Investigation had no powers of compellability, either in respect of the attendance of witnesses or the production of documents or other materials nor was there in place a set of framework arrangements which had been agreed in advance.

It follows that it was necessary to rely on the co-operation of all concerned. In addition it was necessary to devise procedures which were, at the same time, likely to secure such co-operation, to comply with the obligations in law to provide fair procedures but also, at the same time, be such as would enhance the likelihood of any report being both comprehensive and credible.

The reason for setting out the general observations on Inquiries and Investigations in this Report was that the matters addressed informed the process which was followed. It should also be recorded at this early stage that all persons who were requested to attend for interview did so. Furthermore, any information, documents, or materials sought both from UHL itself or from individuals or others was forthcoming.

There is a list of all persons interviewed set out in **Appendix 2** to this Report. That list also sets out whether those interviewed attended alone or accompanied. Where legally represented, the identity of the lawyers is noted. It is worth recording, not least in the context of the observations about legal representation set out in Chapter 10 that the vast majority of those interviewed either attended alone or were accompanied by a colleague or a union representative.

It is particularly important to record thanks at this point.

First and foremost I would like to thank Aoife's parents for the quiet dignity of their evidence. To lose a child is every parents' nightmare. To lose a child in the fraught and traumatic circumstances of Aoife's death is beyond understanding. To be present and feel powerless is unimaginable. All that can be said is that Aoife's parents did everything possible to assist her. It is hard to imagine that it will ever be fully possible to get over the events of the third weekend of December, 2022. There are many steps to even some limited measure of closure. It is hoped that this report may be one step along that journey.

I was greatly assisted in this Investigation by a number of persons to whom I owe great thanks. Dr Mark Doyle and Ms. Marie Burns, experts in respectively Emergency Medicine and Nursing, acted as expert advisors from the beginning of the Investigation. One or other (and often both) attended each of the interviews conducted. They gave most generously of their expertise and time and gave great assistance on many clinical questions that arose.

I was also very ably assisted by the Investigation team of Anne Marie Cullen, Solicitor, Sarah Walsh BL and Jackie Roche, Administrator to the Investigation. Their support and diligence is very much appreciated.

It goes without saying, however, as pointed out to many of those who gave evidence, that responsibility for the contents of this Report is mine alone.

CHAPTER 2 - EXECUTIVE SUMMARY

It is important to start by recognising that this Investigation arises out of the tragic death of a sixteen year old girl in circumstances which, on the basis of all of the medical evidence, were almost certainly avoidable. That human tragedy and the inevitable consequences for her family and friends mandates a thorough investigation.

The fundamental issue concerns the fact that Aoife Johnston presented at the Emergency Department in University Hospital Limerick at 17.39 on the late afternoon of Saturday December 17th 2022 with a letter of referral from an out of hours GP service querying sepsis but was not administered the appropriate sepsis bundle of medication until between 7:15 and 7:20am the following morning.

There was thus a thirteen and a half hour gap between presentation and treatment in circumstances where Aoife attended the Emergency Department having been seen by a GP who queried the possibility of sepsis and where the risk of sepsis was also identified by [Nurse A] who dealt with Aoife. All of that needs to be seen in light of the National Protocol on sepsis which suggests that treatment should take place within one hour.

The starting question has to be as to what went wrong on the night of the 17th/18th December 2022 so as to lead to that delay.

As analysed in detail in the Report the following issues emerged;-

Delay in Triage

(a) It took over an hour before Aoife reached the top of the queue of those arriving in the Emergency Department other than by ambulance to be seen by a triage nurse, see Chapter 4 of this Report.

Nurses and Doctors unaware of sepsis risk

(b) Unlike most patients who are considered to be risk of sepsis, Aoife was not brought to the Resus area after triage (because that area was already grossly overcrowded), but rather was brought to Zone A in the Emergency Department. That of itself did not cause any problems. However, the appropriate sepsis forms that normally accompany a patient who is suspected of having sepsis were, at the time, only kept in the Resus area. As Aoife bypassed the Resus area, no form was filled

out in her case. This undoubtedly contributed to the fact that it appears that none of the nurses or doctors who were involved in dealing with patients in Zone A were aware that Aoife had been identified both by a GP and by [Nurse A] as being at risk of sepsis.

Conflicts of Evidence relating to Aoife being seen by a doctor

(c) There are conflicts in the evidence about the manner in which Aoife's worsening condition led to requests to doctors to see her more quickly than her place in the queue of patients awaiting being seen should have determined. What is, however, clear on the evidence, is that both Aoife's parents, many other patients awaiting to be seen in the Emergency Department and [Nurse B] became increasingly concerned about Aoife's condition and expressed those concerns as best they could. These matters are fully analysed in Chapter 4 concerning the sequence of events and Chapter 5 concerning conflicts of evidence that emerged in the course of this Investigation.

(d) As a result of a request from [Nurse B], Aoife was seen by [Dr D] just before 6am the following morning. The appropriate sepsis bundle of medication was prescribed and it was also determined that Aoife should obtain an x-ray. There are conflicts on the evidence concerning the events surrounding that first x-ray for Aoife. These are dealt with in Chapter 5.

Delay in administering medication

(e) A further period of over one hour elapsed before Aoife was actually administered prescribed medication. This is dealt with in Chapter 6.

Underlying factors which led to the delay in treatment

The Report considers two particular general factors which played a material role in those events. First there is the undoubted fact that the number of patients presenting in the Emergency Department that night was extremely large while the number of nurses was five less than the full roster by reason of absences with the number of doctors being also one below full roster. While a significant increase in the number of nursing posts approved for the Emergency Department had been approved in the summer of 2022, those posts had not been filled by December. The evidence suggests that, as most nurses have to be recruited from outside the EU, it often takes 15 to 18 months to fill newly approved posts.

Patients are triaged in UHL in accordance with the Manchester Triage System. This places patients in categories 1 (the most severe) to 5 (the least acute). Aoife was triaged in Category 2. Under the Manchester Triage System, the ideal maximum time to first contact with a treating clinician for a patient categorised as Category 2, as Aoife was, is 10 minutes. Having regard to the number of patients who were triaged in Category 2 on the occasion in question and the number of doctors available, there was no reality to patients who were categorised in Category 2 being seen by a clinician within anything remotely resembling that timeframe. Indeed, it would appear that it would have taken over 10 hours (as opposed to 10 minutes) to see all Category 2 patients.

An ad hoc system was operating during the period in question whereby nurses could seek to have a patient, about whose deteriorating condition they were concerned, escalated up the list so as to be seen more quickly by a doctor. There is a conflict of evidence, dealt with in Chapters 5 and 6, concerning how that ad hoc system worked in relation to Aoife. Irrespective of that conflict of interest, the evidence suggests that the system, if it can be called that, was inadequate to deal with a very difficult situation where the large number of patients and limited number of nurses and doctors made the monitoring of patients with potentially deteriorating conditions much more difficult. There is now a more objective system in place to deal with potentially deteriorating patients (see Chapter 8).

Conflicts of Evidence over the Escalation Protocol for responding to Overcrowding

The other overriding issue concerns the fact that the problems on the night of the 17th/18th December 2022 were undoubtedly significantly exacerbated by the chronic overcrowding in the Emergency Department on that occasion. Given the numbers of patients presenting, it was inevitable that there would have been significant overcrowding in any event. However, it is clear that the escalation protocol designed to alleviate overcrowding in the Emergency Department was not operated on that occasion (until well into the morning of Sunday 18th). Thus the overcrowding in the Emergency Department overnight was undoubtedly more severe than it should have been. There is a serious conflict of evidence (analysed in detail in Chapter 5) as to why the escalation protocol was not operated.

Lack of Clarity

The evidence in respect of a number of matters suggests that nurse managers on the ground did not have clear understanding in respect of a number of issues which are dealt with in detail in Chapter 5. 1(d). The evidence suggests that this lack of clarity contributed to a number of the issues identified as contributing to the delay in Aoife being treated. The evidence does suggest that, in most cases, decisions had been taken at Senior Management level but that the managers on the ground were not always as clear as to precisely what had been decided.

Among the areas identified where nurse managers on the ground did not have full information on and understanding of decisions taken by Senior Managers were:-

- The operation of a protocol relating to decongestion in UHL's ED particularly after October 23rd 2022;
- The respective roles of the Operational Assistant Director of Nursing and the Executive-on-Call in relation to decongestion;
- The use of sepsis forms for sepsis risk patients who were not brought to the Resus area after triage;
- The process for escalating patients whose condition appeared to be deteriorating;

These and other similar issues are fully analysed in Chapter 8.

The operation of Protocols in challenging circumstances

The evidence also suggests that a number of policies, while likely to operate reasonably well in normal circumstances, were unable to deal with the particularly challenging circumstances present on the occasion in question. While acknowledging that all systems may come under pressure in such challenging circumstances, it should be noted that overcrowding in the Emergency Department in UHL is a regular occurrence and it may well have been appropriate if greater attention had been directed towards the manner in which relevant protocols were to operate in such challenging circumstances.

UHL's lack of capacity-a significant contributory factor to overcrowding in the ED

Finally, it would be unfair both to those who were involved in the Emergency Department on the occasion in question and to Senior Managers if the report did not record what appears, on the evidence, to be a very significant contributory factor to the general overcrowding in UHL's Emergency Department. That factor

concerns the capacity of the hospital itself to absorb all admitted patients. A detailed analysis of this issue is to be found in Chapter 7. However, particular attention must be drawn to the fact that the other Emergency Departments in the Midwest Health Region were closed in 2009 with all serious emergency patients being directed towards the UHL Hospital in Dooradoyle. The concentration of acute services in Dooradoyle was recommended by the Horwath Report in 2008. However, critically, that report emphasised that a relocation to Dooradoyle by closing the other departments should not take place until the capacity of Dooradoyle was increased.

While there are further expansion projects in the pipeline, the fact remains that, even today, some fifteen years later, the capacity of Dooradoyle is significantly below that recommended by the Horwath Report as a pre-condition to closing the other Emergency Departments in the Midwest Region. Indeed, given the increase in demand on acute services in the Midwest Region since the time of the Horwath Report, even those estimates as to the increases needed to facilitate concentration in Dooradoyle are likely to be out of date.

The failure to ensure that the hospital in Dooradoyle had the capacity to deal with the demographic demands following the closure of acute services in the Midwest region is beyond the scope of this Investigation but undoubtedly deserves particular scrutiny by authorities considering the allocation of appropriate services in the region.

CHAPTER 3 - THE PROCESS

3.1. Phase One

In very general terms, the Investigation was conducted in three phases. Phase One involved collating evidence concerning the primary facts surrounding the events of the 17th and 18th of December 2022, obtaining expert evidence to assist me in the identification of any issues requiring further exploration and analysing documentation provided by the hospital. In that context I was furnished with a copy of the Systems Analysis Review report, ("the SAR Report"), dated 30th November 2023, which was also concerned with the death of Aoife Johnston. This Report followed on an external review chaired by Dr Vida Hamilton "the Review Group). Subsequent to obtaining information on the events of the 17th to 19th of December 2022 the Review Group held a Quality Assurance Meeting on the 5th September 2023 with the Executive Management Team of the hospital and on the 7th September 2023 with the Acute Operations and Performance Management & Improvement Unit.

As part of its information gathering process, the Review Group received both a statement from and conducted an interview with most relevant persons. However, due to the unavailability of some persons for interview, written statements only were received in a small number of cases. In conjunction with the SAR Report, I was also, at the same time, furnished with copies of transcripts of the interviews between the Review Group and the individuals concerned together with copies of the statements made to that Group.

It should be noted that a small number of transcripts and/or statements were not amongst the papers initially furnished to me but, as soon as their existence became apparent, same were immediately furnished on request. In addition, as a result of a request for further information to the hospital, the Investigation was informed in January 2024 that transcripts were not always taken in respect of SAR interviews with persons who were not directly involved with the events of the 17th and 18th of December 2022

Having reviewed that documentation, I considered it appropriate to meet first with the family of Aoife Johnston. Such a meeting, which was also attended by lawyers representing the family, took place on Wednesday January 17th 2024. In addition, I wrote to all of the other persons who had either attended an interview with the Review Group or furnished that Group with a statement or both. A copy of a standard form of such a letter is annexed at **Appendix 3**. As appears therefrom, the principal purpose of that letter was to ascertain whether any of the individuals concerned wished to make any alterations to the account which

they had given to the Review Group, failing which it would be possible to treat the transcript and/or statement concerned as evidence in this Investigation.

In the main those contacted in that manner replied by indicating that they either had no additional comments or by making a small number of relatively minor points of clarification. In that context it should be noted that [Senior Staff Member A], who was the [Title] on shift in UHL between 8pm on Saturday December 17th and 8am on Sunday December 18th 2022, did give a detailed additional written statement to me.

3.2. Phase Two

Phase Two involved interviews during which additional information was sought concerning the events of the 17th and 18th December having regard to the evidence already available from the Review Group as confirmed by the various persons who had made statements to and/or had been interviewed by the Review Group, to the expert evidence obtained by the Investigation and also having regard to my interview with the parents of Aoife Johnston. In that context a number of factual issues concerning the events in question emerged which it was necessary to pursue in more detail in the context of Phase Two.

(a) The Escalation Plan Issue

A factual issue arose concerning the circumstances in which an escalation or decongestion plan was apparently not implemented on the night of the 17th December and early morning of the 18th December 2022. The account given to the Review Group suggests that there was a discussion between [Senior Staff Member A] and [Senior Staff Member B], who was the [Title] for the weekend in question, at 22:33 on the evening of 17th December. [Senior Staff Member B] gave an account of receiving a call from [Senior Staff Member A] regarding the situation in the Emergency Department ("ED"). The account given to [them] was that there were 83 patients waiting to be seen with 43 patients awaiting admission. Half of these patients were said to be in isolation. There were more than 30 patients in the paediatric section and it was said that [Dr F] and [Dr G] had declined to come in. As a result of discussions, [Senior Staff Member B] indicated to the Review Group and clarified in [their] initial response to me that [they] discussed various escalation measures involving the use of additional or "surge" beds and "trolleys to go to each ward". [Senior Staff Member B] indicated to me in response to my letter to [them] that, in so far as it was a matter for [them], [they] had given advice to carry out these escalation measures.

However, it would appear that much of this escalation did not in fact occur during the night shift. It follows that it was necessary to obtain further clarity about the circumstances in which that happened, or rather did not happen, and this specific issue was also addressed in the context of Phase Two. A copy of the UL Hospitals Winter Escalation Framework Version 6, dated 24th May 2022 is annexed to this Report **Appendix 4.**

(b) <u>The X-Ray Issue</u>

In the course of the interview with Aoife's parents, a second factual question emerged concerning an account given by the parents of an occasion where an x-ray for Aoife was considered necessary. In a chronology set out in the SAR report it was stated that (see paragraph 8.10):-

"06.00 – 08.00 HRS

....

A chest x-ray was ordered but it appears that this could not be performed as Patient A was too unwell and the parents reported that Patient A told them that a staff member was not very nice to them about their inability to co-operate at there is no record of this x-ray being taken".

On the other hand, on foot of certain data relating to that question being requested of the hospital, the following was stated in an email reply of 15th February 2024:-

"18/12/2022

.... Chest x-ray ordered at 05:53; "arrived "at 05:53; Filmed at 07:05 (there is no evidence of intubation. The radiographer who did this chest x-ray advised AJ was relatively well and stood up for that chest x-ray)."

There was thus some significant lack of clarity surrounding what occurred on the occasion in question having regard both to the recollection of Aoife's parents, the statement in the SAR Report to the effect that there was no record of an x-ray being taken at the relevant time (which seems to be from 6 – 8am on the 18th) but where an initial account from the hospital, while making no reference to a failed attempt to obtain an x-ray, does state that an x-ray was taken in exactly that time period with "arrival" at 5:53 and the x-ray being taken at 7:05. This question was, therefore, one of the matters which required to be addressed in Phase Two concerning the precise events which occurred on the evening and morning in question.

(c) The Doctor Issue

A third factual question also emerged in the context of Phase Two. As will be noted in a more detailed description of the events of the 17th and 18th December 2022[1], the Emergency Department was significantly under staffed on the occasion in question. There was a shortfall of five nurses in the Emergency Department. [Nurse C] dealt with that shortfall by reducing the allocation of nurses in each of the areas within in the ED (with one exception) by one nurse. While it was clearly unsatisfactory that almost all of the areas in the ED were operating with one nurse less than was required, it seems that [Nurse C's] approach was entirely reasonable in the difficult circumstances which [they] faced. Be that as it may, the result was that there was only one nurse looking after all patients who had been allocated to the zone to which Aoife was sent after triage (Zone A) (a more detailed description of the Zones and areas within the ED is set out elsewhere in this Report[2]). In that context it should be noted that other patients, who had already been admitted to the hospital but who remained in the Emergency Department, were looked after by two nurses assigned specifically for that purpose. Those nurses had no role in taking care of patients in Zone A who were awaiting being seen by a doctor.

In addition, there was a shortfall of one doctor on the occasion in question. There was one Registrar already on duty at 8pm whose shift was due to end at 10pm on the 17th December 2022 [Dr A]. In addition to that Registrar, there were two further Registrars rostered between 8pm on 17th and 8am on 18th and one Senior House Officer (SHO) with a similar roster. [Dr C], in fact operated within the so called "Resus" or Resuscitation area during [their] entire shift. [Dr D], was in Zones A, B and C in the ED. [Their] evidence was that [they were] also rostered to look after paediatrics but [were] not called there on the night of the 17th/18th December 2022 and essentially spent most of [their] shift in Zones A, B and C. There was something of a difference in recollection as to the extent to which the second Registrar, [Dr B], may have spent a very significant amount of [their] shift in the Resus area or may have been available to deal with patients in the zones for a reasonable amount of the shift in question. In addition there was a difference in recollection about approaches made during the night by [Nurse B] to certain Registrars concerning Aoife's condition.

[1] Chapter 4, The Events of 17th and 18th December 2022

[2] Chapter 7, Some Broader Issues, The Emergency Department and its Staffing

3.3. The Approach to Conflict of Evidence

As a result of an initial consideration of the Terms of Reference by which I was appointed and having heard Counsel on behalf of the CEO of the HSE in that regard, I determined that it was not within the scope of this Investigation either to make adverse individual findings or to resolve contested issues of fact. The reasons for coming to that view are set out elsewhere in this Report. However it was clear that it was necessary to include, in the Report, an account of any evidence relevant to the issues within the Terms of Reference. In those circumstances it was determined that the appropriate course of action to follow would be to attempt to set out in a full and fair way any competing accounts in respect of questions of fact where there was a conflict of evidence. While this will be dealt with in more detail in due course[3], that process involved affording all parties who were in a position to give evidence in respect of such matters a full opportunity to comment on the evidence of those who gave different accounts. This either involved inviting individuals to be interviewed for a second time or asking for written comments or observations on accounts given by others. A final opportunity to comment on a draft extract of the Report, concerning conflicts of evidence relevant to them, was also afforded.

3.4. Additional Evidence in Phase Two

In addition it should be noted that, in accordance with the Terms of Reference, I had the benefit of expert advice from Dr Mark Doyle, Retired Consultant in Emergency Medicine, and Ms Marie Burns, Director of Nursing at Saolta University Hospital Group, University Hospital Galway. One or both of those experts were present remotely at each of the interviews I conducted and were of considerable assistance in helping me deal with specialist issues.

The Inquest into Aoife's death took place between the 22nd and the 25th of April 2024. I was also provided with the transcripts of the evidence given at that forum.

3.5. Phase Three

In any event, in light of the evidence accumulated during Phases One and Two and having regard to the views of the experts referred to, a number of more general issues were identified with particular reference to the

[3] Chapter 5, The Conflicts of Evidence

requirement in the Terms of Reference to consider questions of corporate and clinical governance in so far as same might have impacted on the events of 17th and 18th December.

Those issues were notified, in April 2024, to what appeared to be the senior clinicians or managers whom it was necessary to interview in Phase Three. The issues in question were set out as follows;-

1. *Whether there were adequate processes in place to ensure proper follow up in respect of patients triaged as Manchester Category 2 with suspected sepsis particularly where that patient was not sent to the Resus area and where there was a very limited number of both doctor and nurse availability in the ED Zones outside of Resus.*
2. *The operation of protocols on "decongesting" the ED where a very large number of admitted patients remained in ED giving rise to extreme overcrowding.*
3. *In the context of (2) above whether there was any process agreed or understood to handle such a situation short of implementing a major incident? If so, who would be responsible for such matters? Were there circumstances potentially meeting the criteria for a major incident? If not, should there be a form of intermediate measure to deal with such a situation.*
4. *Measures adopted to attempt to deal with the regular overcrowding of the ED or desirable measures which could not be adopted because of lack of resources or other such limitations. In that context, it is appropriate to consider also the possibility that staff had become inured to very difficult circumstances and thus less responsive to an even more emergency situation arising.*
5. *It is acknowledged that there are difficulties in almost all Emergency Departments nationwide. In that context it is appropriate to explore whether, and if so to what extent, UHL may suffer greater problems. To the extent that it does, the factors which lead to those additional difficulties require to be explored. This includes any practices which may be different in UHL from some other Level 4 hospitals.*
6. *There are issues about the extent that there were clearly understood lines of command or authority or responsibility in relation to a number of matters. First, as to who was responsible for determining whether particular patients who were awaiting examination by a doctor in ED needed to be prioritised. Second, and connected, as to who had authority to assess and determine such priorities. Both of these matters arise most particularly where there are a large number of Category 2 patients*

awaiting being seen with limited professional staff operating under pressure. Third, as to authority to adopt measures to attempt to alleviate situations of severe overcrowding and the obligation to monitor the progress of any agreed measures. Fourth, the senior "lines of command" and responsibility both within the Dooradoyle hospital and within the UHL Group of hospitals generally.

7. *An issue of fact as to the recommendations made by the PMIU during their involvement with UHL in 2022 with particular reference to the question of patients on trollies being placed on wards in circumstances where a number of witnesses have said that it was their understanding that the PMIU has suggested/determined that such a practice should not occur.*

8. *Finally, as I am required to make recommendations, I would like to explore developments since the tragic event which might be material to such recommendations. Clearly any recommendations will need to acknowledge any positive changes which have occurred or are in the course of being undertaken. I am also happy to hear of any suggested recommendations.*

Having considered the evidence to that point, it was determined that questions arose as to a possible lack of clarity in respect of a number of relevant procedures or practices at the hospital, at least insofar as managers on the ground did not appear to have the same understanding as the Senior Managers interviewed. In that context the relevant Senior Managers were written to with a view to obtaining their observations on those questions prior to the finalisation of the Report in June 2024. This aspect of the Investigation is dealt with in Chapter 9.

In the course of the Investigation I visited the Emergency Department of UHL, Dooradoyle on the 10th May 2024 accompanied by the experts assisting the Investigation, Dr Doyle and Ms Burns. Present at that visit from the hospital were Ms Sandra Broderick Mid-West REO, Dr Damien Ryan Clinical Director Urgent and Emergency Care, Mr Joe Hoare Assistant National Director HSE Estates, Ms Tina FitzGerald, General Manager, Urgent and Emergency Care Directorate, Nurse Evelyn Morris Assistant Director of Nursing Patient Flow and Nurse Smitha Varghese CNM3 (Nurse Varghese was present at Triage and towards the end of the visit).

CHAPTER 4 - THE EVENTS OF 17th AND 18th DECEMBER 2022

4.1. The Sequence of Events

The starting point for any review of these events must be to record that Aoife Johnston registered at the Emergency Department in University Hospital Limerick at 17:39 on the 17th December 2022 with a letter of referral from an out of hours GP service. It was after 7:00am the following morning when Aoife was administered the bundle of medicines prescribed in the case of septicaemia with other investigations also having been prescribed. According to the medical records received from the hospital, the antibiotic ceftriaxone and the steroid dexamethasone were administered to Aoife at 7.15am on the 18th December 2022. The anti-viral medication Acyclovir was administered to Aoife at 7.20am. The relevant extracts from Aoife's medical records are attached at **Appendix 5** to this Report. It is recommended that patients with septicaemia receive the relevant medication within one hour so that, even allowing for some period for triage and some gap between first seeing a doctor and receiving treatment, there was a very significant and wholly unacceptable delay in the relevant treatment being provided.

In so far as this Investigation is concerned directly with the events which occurred on that occasion, then the focus has to be on the factors which seem to have contributed to that delay. Notwithstanding receiving treatment, tragically, Aoife did not survive. The medical evidence suggests that she would have had a good chance of survival had she been treated in the manner which relevant protocols suggest. It also seems to follow that time was of the essence. The earlier treatment might have been administered, the greater the chances of a successful outcome. It is not, therefore, possible to be certain about what the outcome would have been had the relevant treatment been provided at any particular, but earlier, stage between the early evening of the 17th and the time when treatment was actually administered after 7am on the 18th. However, it can be said with confidence that any factors which potentially played a role in delaying the administration of that treatment decreased the chances of a successful outcome for Aoife.

It is, therefore, necessary to look at the sequence of events with a view to determining the factors which contributed to that reduced chance of a positive outcome.

It is also important to emphasise that all of the evidence points to the fact that the Emergency Department in UHL, on the occasion in question, was under unusually severe pressure. Other parts of this Report will

require to address some general issues as to the factors which led to that situation[4]. Some of those factors apply to all EDs in the State but it will also be necessary to consider whether the clinical and/or corporate governance of UHL contributed to those factors insofar as they applied in that hospital. However, whatever may be the answers to those questions, the staff working in the ED on the occasion in question were undoubtedly faced with an extremely difficult situation, and it is necessary to take that into account in assessing what happened. This aspect of the Report is concerned solely with what happened on the 17th and 18th December and the extent to which, even operating within the difficult circumstances that prevailed, the manner in which Aoife's situation was handled could or should have led to her being treated at an earlier stage with the increased possibility of the positive outcome to which I have already referred. The sequence of events was as follows:

- Aoife Johnston registered in the Emergency Department at University Hospital Limerick at 17.39 on the 17th December 2022 with a GP referral letter querying *"viral septicaemia and dehydration"*. She was accompanied by her parents.
- At 19.13 on the 17th December 2023 Aoife's was triaged by [Nurse A] and assigned a Manchester Triage Category of 2 (Category 2). [Nurse A] wished to send Aoife into the Resus area given her presenting symptomology and the concern about sepsis. [They] spoke with a Registrar and it emerged that Resus was over full. Aoife was sent to Zone A in the Emergency Department. [Dr A] gave evidence at Day 2 of the Inquest into Aoife's death that [they] signed Aoife's ECG (page 56, Day 2 Inquest Transcript)
- [Nurse B] was the [nurse] on the night shift. [Their] evidence was that it was not brought to [their] attention that Aoife was query sepsis (page 5 Investigation Interview).
- Aoife was prescribed Paracetamol, Ondansetron and Zofran intravenously by [Dr A]. [Dr A] gleaned this from reviewing the notes but had no particular memory of the event (page 14 and 15 Investigation Interview)). The medical records reference an administration time of 20.25.
- 22.30 Aoife's father requested a trolley for his daughter. None was available.
- 23.50 [Nurse B] checked on Aoife who was nauseated and vomiting. [They] approached a doctor who prescribed anti-emetics and IV fluids. Aoife was not seen by a doctor at this time, nor was examination requested by [Nurse B].

[4] Chapters 6 and 7

- Aoife was moved to a trolley at approximately midnight.
- Repeat vitals were taken from Aoife at 1.40am and reported to [Nurse B]. Aoife's blood pressure was low, her heart rate slightly elevated and she had a temperature. She complained of aches and pains in her legs. [Nurse B] gave evidence that [they] went to Resus and spoke to [Dr B], explaining the situation. Aoife was prescribed intravenous Keral and elevation of her legs was advised. [Nurse B] gave evidence that the doctor told [them] [they] could not come and see Aoife due to the acuity of patients in Resus at that time (page 13 Investigation Interview). [Nurse B] was questioned on this at interview (page 13): *"Q. Okay. So did you ask [them] to come out and see her or was it just that [they] said [they] couldn't? Ans: [They] said [they] couldn't".* [Dr B] at [their] Investigation Interview (page 14) stated that [they] had no recollection of being asked to see Aoife.
- Medications were administered to Aoife as prescribed.
- [Nurse B] reviewed Aoife again at 2.30am. Aoife remained pyrexic. [Nurse B] took blood cultures and a urine sample. Aoife was assisted to the bathroom by her mother with the use of a wheelchair.
- [Nurse C] carried out so called Safety Pauses in the ED (where the lead nurse in each Zone would report on patients in their area to [them]) at 2.30am and 4.30am. [Nurse B] gave evidence that she escalated Aoife's case to [Nurse C] at 2.30 and 4.30am (page 18 Investigation Interview, [Nurse B]).
- [Nurse B] gave evidence that [they] assessed Aoife again at 4am. Aoife was hypotensive, tachycardic and pyrexic. [Nurse B] gave evidence that [they] went to Resus and spoke to [Dr C] (page 15 of [their] Investigation interview). On [their] account [they] relayed the symptoms to [Dr C] who thought it sounded viral and advised to continue paracetamol every four hours. [Their] evidence was that [Dr C] said that [they] could not review Aoife due to acuity in Resus. [Nurse B] gave evidence that [they] requested that Aoife be moved to Resus for further management but that [Dr C] was of the view that, as Aoife had had interventions, this was not necessary. [Nurse B] says that [they] requested that an antibiotic be prescribed but that an antibiotic was not prescribed at this time. [Dr C's] evidence was that no one approached [them] about the possibility of escalating Aoife (Pages 11 and 12 of [their] Investigation Interview). This is a conflict in evidence between [Nurse B] and [Dr C].
- [Nurse B] gave evidence that [they] escalated [their] concerns about Aoife to [Nurse C] at the Safety Pause at 4.30am.

- [Nurse B] spoke to [Dr D] at 5.45am about Aoife. Aoife was not improving despite multiple interventions. [Dr D] agreed to see Aoife, ahead of other Category 2 patients awaiting medical assessment, at approximately 6am. Aoife was complaining of pain and aches in her legs. Oxynorm was prescribed by [Dr D] and administered in advance of [them] seeing Aoife.
- [Dr D] reviewed Aoife, queried *"viral septicaemia/septic shock,?CNS sepsis/strep pharyngitis".* [They] prescribed antibiotics, ordered other investigations and spoke with the on call medical team SHO and requested a review of Aoife for admission, diagnosis and treatment.
- [Dr D] requested an x-ray. Records suggest that the x-ray request "arrived" at 5:53. On the evidence this seems to refer to the fact that the request by a doctor for an x-ray arrives electronically in the x-ray system and does not suggest that the individual who was to have the x-ray taken had actually arrived in the x-ray department. Factual issues surrounding the x-ray issue are addressed elsewhere in this Report.
- [Dr D's] evidence was that, as [they] left the room porters came to take Aoife for x-ray. [Dr D's] account was that Aoife's mother advised that Aoife did not feel up to it and asked could they wait. [Dr D] recalled that the porters were slightly annoyed by this.
- At a later time Aoife was taken for x-ray by [a Health Care Support Staff member]. At interview with the Investigation the relevant [Health Care Support Staff member] gave an account of attending on Aoife in Zone A, of speaking to her parents about whether she could move from her trolley to a wheelchair and being told that this was possible. [They] described bringing Aoife in that chair to the x-ray department and back but indicated that [they were] not present for the taking of the x-ray itself.
- The x-ray itself was taken after 7 o'clock, Aoife having being brought to X-ray by [the Health Care Support Staff member] in a wheelchair, so that the record suggests that there was a gap of well over one hour between the request being made and the x-ray actually been taken. The issue of the x-ray will be dealt with further later in this Report.
- Antibiotics and steroids were given to Aoife between 7.15am and 7.20am according to the medical records received from the hospital.
- 7.45am Aoife's mother went to the nurse's station seeking help. Both parents were very concerned for their daughter.
- [Nurse B] at 8.00am found Aoife at the bottom of her trolley distressed and agitated. Both her parents were very concerned and upset. With the assistance of her parents Aoife was moved back

onto the trolley. [Nurse B] repeated vitals and found [Dr B] (Page 23 [Nurse B's] Investigation Interview)

> I found [Dr B] and basically was asking for a review. At that stage then it was kind of around I would say 8:15 when the two girls I was working with that night came up to me and I was like 'can you please move Aoife to Resus'. At that stage then I came back and I handed over the rest of the patients that were in that night and that was really it.

- Aoife was moved to Resus. Aoife's parents recall holding their daughter down so she could receive treatment.
- 9.00am sedation was given to Aoife and she underwent a CT scan. A decision was made to intubate Aoife. She was subsequently transferred to ICU.
- At 13.34 a third CT scan showed significantly reduced blood flow to Aoife's brain due to brain swelling within the rigid confines of the skull.
- 15.20 Aoife's parents were updated on the CT scan results and told that there was no indication for neurosurgical intervention. It was explained that brain death was a possibility.
- Brain stem tests were carried out on the 19th December 2022 in accordance with protocol and brain stem death was confirmed following the conclusion of both sets of tests.
- Aoife Johnston was declared dead at 15.31 on the 19th December 2022 with her family in attendance.

One matter stemming from that chronology is worthy of some consideration by the relevant authorities. As can be seen, the fundamental problem was that the relevant Sepsis bundle was not prescribed for over 12 hours after Aoife presented at the ED and was not administered for over 13.5 hours after that first presentation. However Aoife had been seen by a GP who considered that there was a risk of Sepsis. While the issue is beyond the scope of this Report, consideration might be given to determining whether there should be circumstances in which it could be recommended that a GP, on identifying a risk of Sepsis, might be able to take the initial treatment steps required at that time while also referring the patient to an ED for further assessment and, if necessary, treatment. If it did prove possible to put such a practice in place, then the patient would at least have a timely initial treatment pending such additional measures as might be considered appropriate after a visit to the ED. It is the Investigation's understanding that Advanced Paramedics in the National Ambulance Service have protocols for administering antibiotics.

In addition, it is clear that it took more than one hour from the time Aoife presented at the ED to the time when she was seen by a triage nurse. There would appear to have been two nurses assigned to triage at that stage. The evidence suggests that nurses required to have a particular level of experience before it is appropriate that they be assigned to that important role which does, after all, significantly influence the pathway which a patient follows in the ED. It appears to be the case that patients are seen by a triage nurse in chronological order by reference to when they register at the ED. In passing it should be noted that patients who arrive by ambulance enter the ED by a different route and are dealt with in a different manner. There is nothing in the evidence to suggest that the reason for the delay in Aoife being triaged was due to anything other than the number of patients presenting. However it does raise issues as to whether additional measures may need to be put in place to ensure that patients, who may potentially need urgent treatment, can be triaged in a speedy fashion. It is appreciated that it may not be particularly easy to put in place an improved system in this regard having regard to the resources generally available. However some consideration should be given to identifying whether there are ways in which patients who are potentially in need of more urgent treatment, but who do not arrive by ambulance, can be assessed in triage more quickly.

Apart from the contested questions of fact and the more general issues referred to earlier, a number of specific issues arise in the context in that sequence of events. I propose to deal with them in turn at this stage.

4.2. Some Issues arising from the Sequence of Events

(a) The Identification of a Risk of Sepsis

It is clear that both the referring doctor (who was an out of hours GP) and [Nurse A] both identified a risk of sepsis as an issue. The question which arises is as to whether those facts should have led to a different pathway for Aoife in the ED on that occasion. Under the Manchester Triage System the ideal maximum time to first contact with a treating clinician for a patient categorised as Category 2, as Aoife was, is 10 minutes. Annexed to this Report at **Appendix 6** is Chapter 1 “Emergency Triage 3rd Edition, Manchester Triage Group” received from nursing expert Ms Marie Burns, Director Nursing, Galway University Hospital. While some persons interviewed suggested different periods for first treating clinician contact with Category 2 patients, the actual Manchester Triage System is clear that the relevant period is 10 minutes. Likewise, the protocol in respect of sepsis treatment suggests that a patient diagnosed with possible sepsis should receive a bundle

of treatment within one hour. The question then arises as to how a patient presenting with a GP indication of possible sepsis and who is likewise triaged in a similar vein, should be dealt with in circumstances where there is no reality to complying with those protocols if the patient takes their ordinary place in what might be described as the queue.

Under the system then operated by UHL ED it would appear that patients in each category are ordinarily seen by a doctor in chronological order by reference to the time at which they were categorised. The evidence was to the effect that patients are sometimes seen out of that order as a result of a nurse identifying a particular need for a patient to be seen in an urgent way. Ultimately, it would appear that the decision as to whether to escalate a patient ahead of where they might normally appear in that "queue" is taken by the relevant doctors on the ground.

It is appreciated that there are patients other than sepsis risk patients in respect of whom there are protocols as to the time within which they are to be treated. In addition, all patients triaged as Category 2 have been found to be seriously ill and in need of urgent attention from a clinician. However, it was not clear to me that, at the time in question, there was any systematic way in which patients, whose condition (or suspected condition) was such that there were protocols in place requiring them to be dealt with within a short timeframe, were to be dealt with in circumstances where the overall demand was such that the ordinary operation of the Category 2 list of patients was likely to lead to any patient who was not so escalated being seen no earlier than 8 to 10 hours after presentation (and possibly longer).

Undoubtedly, relevant protocols provide for what is to occur in ordinary circumstances if not in an ideal world. There may be situations (and it would seem that the situation on 17th and 18th December 2022 was one such) where it may have been impossible to actually comply with all relevant protocols. However, that this may be the case does not seem to me to take away from the fact that there needs to be some established system for handling situations such as that which pertained on the night in question. The fact that circumstances may be far from ideal, and that strict compliance with all relevant protocols may not be possible, does not mean that there should not be a method for identifying particular priorities. For example, if all Category 2 patients were to be seen within the time anticipated under the Manchester System, then it would be unnecessary to have any other method for supplementing that system in respect of prioritising patients within that category. All patients would be seen in a timely fashion and appropriate protocols in respect of their treatment complied with. Even if the delay in seeing patients were a little beyond that which

the Manchester protocol might suggest, then perhaps no great difficulties would arise. But where, as happened here, there were a very large number of patients in Category 2 with no hope of most being seen for upwards of 10 or more hours unless they were escalated up the list, then the question arises as to how such a situation is to be managed as and between the needs of patients in Category 2 and with particular reference to patients who have conditions, or suspected conditions, where there are other protocols suggesting intervention within a particular timeframe or where there are particular concerns about their condition. Leaving the situation to one where nurses under pressure can seek, on what is effectively an informal or ad hoc basis, that doctors, equally under pressure, escalate individual patients, seems to me to be hardly an ideal process. It is outlined in Chapters 6 and 8 of this Report that some progress in this regard has been made since December 2022.

It will be necessary to address the impact of this question on Aoife's situation in more detail in due course.

(b) Decongestion

All of the evidence points to the fact that a significant contributory factor to the circumstances pertaining on the 17th and 18th December was the exceptional level of overcrowding in the ED and, in particular, the number of patients who had been categorised in Category 2 on that occasion. On December 17th 2022, presenting to triage between 00:00 hrs to 23.59, were two Category 1 patients; 94 Category 2 patients, 127 Category 3 patients and 14 Category 4 & 5 patients[5]. 42% of all presentations were thus Category 2. The national average is 22%. The evidence suggests that the ability of both doctors and nurses to do their job in an ordinary way is materially compromised by overcrowding and can be significantly compromised where that overcrowding is severe. Understandably patients, or those advocating for them, will make repeated requests to doctors and nurses on the floor where they have been waiting for a long time to be seen or where they are waiting for results of tests specified by the clinical staff. The need to politely explain to patients about the order in which they will be seen takes time. One senior nurse described a situation, not on the occasion in question, when returning to her station she had to speak to upwards of 20 people making enquiries of that type. The time taken to do that was time that could have been spent dealing with other clinical issues. In addition medical staff had logistical difficulties in simply moving around the ED given the sheer volume of patients (some with family members) in the department on the night in question with very

[5] SAR Report, page 27

many trolleys on corridors. There can be little doubt, therefore, that the efficiency of a significantly overcrowded ED falls materially below the efficiency of a similar ED operating in uncrowded conditions. Obviously, there may be other factors which impact on the number of patients that can be seen by a particular number of doctors within a particular timeframe. Some patients and some conditions inevitably will require more time than others. If there are, on average, more patients requiring a greater length of assessment, then the number of patients seen will inevitably be less. But equally there can be little doubt but that significant overcrowding contributes materially to a reduction in the speed with which any given number of doctors can assess and treat ED patients. It follows that, to the extent that the overcrowded conditions on the occasion in question may have materially contributed to the delay in Aoife being seen by a doctor, it is necessary to analyse whether decisions taken contributed to that overcrowding. In that context it is important to emphasise that it will be necessary, separately in this Report, to address more general questions concerning the factors that may have influenced overcrowding in UHL ED on many occasions beyond the weekend which is the particular focus of this Investigation. However, notwithstanding the difficult situation which regularly pertained, it will be necessary to look at the particular circumstances of overcrowding on the occasion in question.

On the evidence, it would also appear that there is a potential connection between overcrowding and the question identified above as to the ad hoc method then in use for seeking to identify patients whose condition was worsening to the extent that consideration ought to be given to the patient concerned being escalated “up the list”. The ability of nurses on the ground to effectively monitor all of the patients within a relevant part of the ED is undoubtedly influenced by the number of patients which any one nurse has care of. As already noted, there was just one nurse in Zone A on the occasion in question with, at any given time, a very considerable number of Category 2 patients in that zone awaiting to be seen by a doctor. However apart from that question of resources, the evidence suggests that a nurse’s ability to properly monitor patients was understandably compromised if the conditions in the zone to which the nurse concerned was assigned were so overcrowded that observation was necessarily impaired. It is for reasons such as those that the question of overcrowding is undoubtedly material to any analysis of the reasons why there was such an unacceptable delay between Aoife’s arrival in the ED and her ultimately being administered the so called “sepsis bundle”.

However, before seeking to analyse the various factors that may have contributed to that delay, it is necessary to address in more detail the conflicts of evidence which relate to issues potentially relevant to that overall question.

CHAPTER 5 - THE CONFLICTS OF EVIDENCE

5.1. The Decongestion Issue

The first such issue arises in the context of why agreed decongestion measures were not implemented in the Emergency Department of UHL on the 17th December 2022.

The SAR Report dated 30th November 2023 found that

"The escalation protocol was not adhered to on Sat 17th day or night despite numbers of patients waiting varying between 42 to 55 awaiting inpatient beds.[6]

The SAR Review Group recommended:

"That a 'zero' tolerance approach to admitted patients being boarded in the ED be taken....This requires the identification and preparation to take excess patient numbers in all areas at all times and for bed management to allocate admitted patients to the next identified area as soon as they are designated for admission and for the transfer to occur in a timely and efficient manner and not delayed until morning or any other pre-specified time."

As a result of the evidence gathered during this Investigation, a significant and material conflict of evidence has emerged in respect of whether or not an instruction was given that trolleys bearing admitted patients were to be placed on wards on the night and morning of the 17th and 18th December in an effort to ease pressure on the ED. As indicated earlier, the Terms of Reference under which this Investigation has been conducted does not involve the resolution of such conflicts of evidence. However, the competing accounts require to be fairly and comprehensively set out as does the process by which those accounts emerged. It is, however, important to start by indicating, at a general level, the substance of the conflict of evidence.

(a) An Outline of the Issue

The starting point has to be to note that there was agreement concerning a phone call which took place at 10.33pm on the evening of Saturday December 17 between [Senior Staff Member A] and [Senior Staff Member B]. [Senior Staff Member A] contacted [Senior Staff Member B] in respect of the situation in the Emergency Department.

[6] SAR Report, page 50

Both agreed that the emerging situation in the Emergency Department was discussed and that it was determined that a surge facility would be opened (the Surgical Day Ward). The Surgical Day Ward can accommodate 10 beds and it was agreed that 7 patients would be sent there. Following interviews this Investigation enquired of [Senior Staff Member B] and [Senior Staff Member A] as to why the beds in the Surgical Day Ward were capped at 7. [Senior Staff Member B] responded by email dated the 12th May 2024 saying that, while beds were capped at 7 [they] could not, at this remove, remember the rationale for this and stated that

"While I believe that there was spatial capacity for 10 beds in the Surgical day ward, this would be subject to the Nursing team having sufficient staff to care for the needs of the patients."

[Senior Staff Member A's] response, by email dated the 11th May 2024, was that

"A cap of 7 patients was agreed between [Senior Staff Member B], and myself which would have been the norm to facilitate elective activity on the Monday. On that night elective activity had not yet been discussed with a view to stepping down the service as a result of surge in activity."

It was also agreed by [Senior Staff Member B] and [Senior Staff Member A] on their telephone call on the night of the 17th December 2022 that the Emergency Department would be further decongested by sending admitted patients on trolleys to wards. It will also be necessary to deal in some greater detail with a controversy which had, prior to the occasion in question, surrounded the issue of admitted patients on trolleys being placed on wards. However, for present purposes, it is sufficient to note that there was agreement that admitted patients on trolleys would go to wards on this occasion in an effort to deescalate or decongest the situation in the Emergency Department.

Where the conflict of evidence arises is as to what happened next. The conflict lies between, on the one hand, [Senior Staff Member A] and [Nurse D] and, on the other hand, [Nurse C] and [Nurse E].

The two more senior nurses gave evidence that, on foot of the discussion between [Senior Staff Member A and Senior Staff Member B] it was indicated to [Nurse C and Nurse E] that admitted patients on trolleys should be sent to wards. On the other hand, both [Nurse C and Nurse E] suggest that no such instruction was given with [Nurse C] stating in evidence that [they were] told that trolleys were not going to wards overnight.

There is, in fact, no dispute but that admitted patients on trolleys were not sent to wards during the continuance of the night shift up to 8am the following morning. The dispute is as to why that did not happen. On one account, instructions were given that this was to occur, but, for whatever reason, those instructions were not followed. On the other account, no such instructions were given but rather it was indicated that no trolleys were to go to wards overnight.

There is a second conflict of evidence in the same context as to whether there was mention of this issue during a phone conversation between [Senior Staff Member A] and [Senior Staff Member C].

Before going on to set out the conflicts of evidence in that regard in more detail, it is important to record a number of observations about this dispute.

(b) Some Preliminary Observations

First, it should be said that, because such a dispute has emerged on the evidence, it has been necessary to deal with this issue in significant detail. The level of detail into which this issue has been explored should not unduly exaggerate its importance. The issue does, however, remain one of some significance. As noted elsewhere, an important consideration in any assessment of the reasons why Aoife Johnston was not seen by a doctor for a very prolonged period of time stems from the significantly overcrowded nature of the Emergency Department on the occasion in question. It is clear that, had Aoife been seen by a doctor and the appropriate sepsis treatment given at a significantly earlier stage, then there was a very good likelihood of a positive outcome. It is also tragically clear that, by the time the treatment in question was actually delivered, it was too late.

It is impossible to tell, at this stage, as to the precise time, during the interval between Aoife's first arrival at the ED and treatment ultimately been given, when it became too late but there can be no doubt that the greater the delay the greater the risk of the tragic outcome which ultimately occurred and, consequently, the less the delay the greater the chance of there having been a positive outcome. It follows that any factors which may have contributed to that delay are potentially relevant to any assessment as to what went wrong. It follows in turn that, to the extent that overcrowding contributed to that delay (an issue analysed elsewhere), the causes of that overcrowding and measures which might have reduced, even if not eliminated, same are very material. However, there are other factors which also need to be taken into account in attempting to determine why it was that Aoife was not seen by a doctor for such a prolonged period. The fact that those

factors can be described in a more concise way than can the trolleys issue with which this part of the report is concerned should not be taken to imply that those other issues are necessarily less significant.

In addition, it is of some relevance to recall that the SAR Report emphasises the need for the transfer process from ED to occur in a timely and efficient manner and not be delayed until morning or other pre-specified time. In the SAR Report [Nurse C] is noted as stating that at 0345 on the 18th December 2022 [they] contacted [Senior Staff Member A] looking for support and requesting that trolleys go up to wards and was told that no trolleys would be going up on the wards overnight[7]. In that context, it is relevant to note that [Nurse E] was not asked to give an account to the previous Investigation, which culminated in the SAR Report. In addition [Nurse D], while giving a written statement to that Investigation, was not in fact interviewed. [Senior Staff Member A] did give an account to the previous Investigation which is consistent with the account [they have] now given to me. It is correct to state that [they were] one of those persons who were shown a draft of the report of the previous Investigation and invited to make comments. [They] explained to this Investigation that, at the time when [they were] asked to make such comments, [they were] dealing with some ██████ matters and did not, therefore, draw attention to the fact that the draft report appeared to accept as uncontested an account contrary to [their] own.

In any event, it is next necessary to turn to a more detailed account of the conflict of evidence in question and the process which was followed so at to give all relevant parties an opportunity to have their account fully and fairly set out in this Report.

(c) <u>The Decongestion Conflict in detail</u>

As noted earlier, the SAR report set out the evidence of [Nurse C] which suggested that it had been determined in the early hours of Sunday 18th of December that no trolleys would be going up on the wards overnight[8]. No alternative version is mentioned. In light of that, when interviewed by this Investigation, [Nurse C] simply confirmed the account which [they] had given to the previous Investigation to the same effect and was not asked about the alternative version which has now emerged. [Nurse C] gave evidence that [they were] told that trolleys were not going to wards overnight (page 46, Investigation Interview 23rd February 2024):

[7] SAR Report, Page 36
[8] Ibid, Page 36

I again spoke to [Senior Staff Member A] around trolleys going up on
wards again and I looked for that escalation and I was told that wasn't going to happen overnight.

Q[9]. Were you given any reason for that at that stage?

A[10]. [They] said to me that the trolleys wouldn't go on wards over night because the surge area was open and that would be the last option for the following day basically.

Around this time, as a result of enquires made to the hospital by this Investigation, it also became apparent that [Nurse E] was part of the team involved on the occasion in question. In [their] interview with this Investigation, [Nurse E] also gave an account consistent with that of [Nurse C] to the effect that [they were] not instructed to move boarded patients in the ED on trolleys to wards (page 15 Investigation Interview 23rd February 2024). [They] also gave further details of the process by which patients admitted through ED were provided with beds when available. For example [they] gave an account of how a thorough examination was made of available beds at the commencement of [their] shift. It was clear that, on the occasion in question, there were already a large number of patients who had been admitted but for whom "ordinary" beds on wards were not available. At 8pm on the 17th December 2022, 35 patients were being 'boarded' in the ED i.e. admitted to the hospital and awaiting an available in-patient hospital bed (page 27 SAR Report). [Nurse E's] evidence was that on the 17th [they] admitted 27 patients from the Emergency Department, 18 adults and 9 paediatric patients (page 22 Investigation Interview 23rd February 2024). It proved possible to find beds for some of those (seven went to the surge area, 9 of the remaining 20 went to paediatrics, 11 to ordinary hospital beds). However, notwithstanding the utilisation of all available beds, there remained a significant number of patients who, although admitted, remained on trolleys in the Emergency Department. [Nurse E] gave evidence to this Investigation that on the morning of the 18th December 2022 there were 49 patients in the Emergency Department plus two in the Clinical Decision Unit that were awaiting in house hospital beds and of that 28 were reported requiring isolation (page 23 Investigation Interview 23rd February 2024).

[9] 'Q' represents questions asked by the Investigator

[10] 'A' represents answers given by the Interviewee to the Investigator

[Nurse E's] evidence was that approximately 20 admitted patients were being boarded in the ED without specific isolation needs and could have been moved on their trolley to the wards if the instruction to do so have been given, which it was not (Page 23 Investigation Interview 23 February 2024)

In that context, it is appropriate to note the protocol then applicable to such a situation which was the UL Hospitals Winter Escalation Framework Version 6, dated 24th May 2022 which is annexed to this Report at Appendix 4. In that 2022 framework, where more than 23 admitted patients were boarded in the ED, this should result in efforts to decompress the hospital, by opening surge capacity and placing patients on trolleys on the wards.

It must be mentioned that the SAR Report (page 29) refers to being informed by interviewees that the Hospital Escalation Protocol 2020 was

"the one in common usage in the ED at that time".

That 2020 protocol is annexed to this Report in **Appendix 7,** for the sake of completeness.

Be that as it may, [Senior Staff Member D's] evidence at page 46 of [their] Investigation Interview was that the escalation protocol being adhered to in December 2022 was Version 6, May 2022. [Senior Staff Member E's] evidence (page 56) was that the position in December 2022 was that when that protocol requirement of 23 trolleys in the ED was exceeded, then the protocol should operate with surge facilities being opened and trolleys with boarded patients taken to wards.

[Nurse C] was the [Title] on the night of the 17th and 18th December. [Their] evidence (page 30 and 31 Investigation Interview 23rd February 2024) was that [their] understanding of the most recent protocol that was in place was that

"..once the department hit 23 admitted patients that trolleys were supposed to go to, one round of trolleys to go to every ward or whichever wards can take them, once there was 23 admitted patients within the Emergency Department".

[Nurse E]'s evidence (pages 13 and 14 Investigation Interview 23rd February 2024) was that once there were 23 boarded patients in the ED and escalation was ordered with trolleys to go to the wards 17 would go up in the first phase, then 15 in the second phase and finally 7 in the third phase making a total of 39 trolleys that could go the wards.

[Senior Staff Member A] during [their] Investigation Interview on the 4th March 2024 at pages 9 and 10 while addressing [their] understanding of a separate issue concerning policy on trolleys on wards in UHL (and to which it will be necessary to return) did make reference to there not being a clear escalation policy in place:

That was a challenging piece there, you know, because we didn't have a clear escalation then at that stage to say okay, if we have 20 boarded in ED then we escalate, we move to trolleys at ward areas so that was a grey area there then.

The reference to 20 boarded would appear to be a reference to the 2020 Protocol.

Ultimately on the night in question the numbers of boarders on trolleys in the ED well exceeded what which would trigger escalation applying either protocol.

It will be necessary to return to the applicable protocol in due course.

In any event, by the time that [Senior Staff Member A] and [Nurse D] were interviewed by this Investigation, it was possible to put to them the suggestion, consistent with both the earlier SAR Report and the evidence of [Nurse C] and [Nurse E], to the effect that they were not instructed to send trolleys with boarded patients from the ED to wards. Both [Senior Staff Member A] and [Nurse D] disagreed with this suggestion. Their disagreement, and in particular that of [Senior Staff Member A], involved giving a detailed account of interactions with [Nurse C] and [Nurse E] concerning instructions to move forward with the process of putting patients on trolleys to wards. On the account of [Senior Staff Member A], this involved giving specific directions to the effect that it would be necessary to provide a justification for leaving any relevant patient in ED, where there was said to be a legitimate basis for that patient being considered unsuitable to go to a ward on a trolley.

It is necessary to address the background to that issue which stems from the fact that, at the time in question, there were a number of bases on which it was suggested that, for clinical reasons, particular classes of patients should not be placed on trolleys on wards. A copy of the applicable protocol was provided to this Investigation by [Senior Staff Member A] and is annexed to this Report at **Appendix 8.** As can be seen from that document, there were a significant number of categories of patients who were not considered suitable in that regard at that time.

In passing and also in that context, it should be noted that the protocol in question has been changed since that time with a significant reduction in the number of types of patients who are now not regarded as

appropriate for being placed on trolleys on wards. There are, for example, obvious cases where there is a proper basis for not sending particular patients to wards such as patients who might be infectious and who might infect others on the ward in question. However, on the basis of the evidence given to me by Dr Doyle and Ms. Burns, it seems clear that the original protocol was overly restrictive in that it sought to exclude an excessive number of categories of patient from being considered suitable to be sent on trolleys to wards. The issue is not as to whether it is ideal for a particular patient to be on a trolley on a ward but rather whether there is any material difference between such a patient being on a trolley on a ward and the same patient being on a trolley in an overcrowded Emergency Department. It may well be the case that neither of those scenarios could be considered to be ideal from the patient's perspective but, in the absence of what might be called an "ordinary" bed being available, there is no option but for the patient to be in one or the other situation. In that type of circumstance, the fact that being on a trolley on a ward may not be ideal does not mean that it would be any less appropriate than being left on a trolley in an overcrowded ED. The effect which the location of such patients might respectively have on the proper operation of the ED and on the relevant wards is also a consideration.

Be that as it may, [Nurse E], in [their] interview with the Investigation on the 23rd February 2024 and at pages 16 and 22 and 23 of the transcript, made clear that there were certainly a sufficient number of admitted patients who would have been suitable to transfer on trolleys to wards on the occasion in question should an instruction in that regard have been given.

Q. But you were not told that there was any authority to move patients to the wards?

A. No.

Q. And therefore it would have been possible at least in theory, that another 30 odd could have gone to wards and you probably had enough patients that, even if you excluded some who weren't suitable, you probably would have had 37 who could have gone?

A. Well from the figures that I reported in the morning there was 49 patients in the Emergency Department plus two in the Clinical Decisions Unit that were awaiting in house hospital beds and of that 28 were reported requiring isolation.

Q. Okay. There was another 20 even if you leave out the isolation?

A. 20 odd, yeah, exactly.

Q. So there was 20 people who could have been moved to a ward but because the authority wasn't given for that it didn't happen, is that essentially that?

A. Yes.

Q. You could have picked those 20. I am sure you could have been asked at any time in the evening who were the ones that could go?

A. Yeah.

In the course of their interviews with this Investigation, the accounts previously given by [Nurse C] and [Nurse E] were then put to both [Senior Staff Member A] and [Nurse D]. Their contrary accounts were, therefore, given in the knowledge of the evidence given to the Investigation by [Nurse C] and [Nurse E]. In substance, their account was to the effect that the instruction was given to move admitted patients on trolleys to wards and that those instructions were pursued during the night in question but, for reasons which they could not explain, those instructions were not followed. [Nurse D] agreed with the substance of [Senior Staff Member A's] account in so far as it related to the instruction being given to move trolleys with admitted patients from the ED to wards.

In light of the very stark conflict between the relevant witnesses and of the fact that neither [Nurse C] nor [Nurse E] had been given an opportunity to comment on the evidence subsequently given by [Senior Staff Member A] and [Nurse D], fair procedures clearly required that [Nurse C] and [Nurse E] be given such an opportunity. For that reason, they were asked, and did, attend for further interview at which the accounts given by [Senior Staff Member A] and [Nurse D] were put to them. They fully re-iterated their original evidence and rejected the accounts given by [Senior Staff Member A] and [Nurse D].

[Nurse C's] response when [Senior Staff Member A's] account was put to [them] at [their] second Investigation Interview on the 22nd March 2024 was at page 6 (emphasis added):

Well, Judge Clarke, I suppose the gravity of the situation when I came on that night was so clear to me that by 10 o'clock I was looking for that escalation to happen to decongest that department. So with looking for a major emergency to be declared, that is the highest level of escalation that could be sought. So I had spoken to [Senior Staff Member A] at 10 o'clock to say that my department was in a major emergency situation by 10

o'clock because I knew, with the level of acuity and category 2 patients in the department. So when [they] came down to me and after I spoke to the consultants and asked them to come into the department to give support and clinical guidance within the department, [Senior Staff Member A] told me [they] would speak to [Senior Staff Member B] and
come back to me with a plan. When [they] came back to me [they] told me that they were opening surge and when I said to [them] about the trolleys [they] said a decision around the trolleys would be made later in the night.
I reverted back to [them] again at 3 or 3:30 again about trying to decompress the department and getting trolleys to wards. One hundred percent [they] said to me that the trolleys would not be going up overnight, that that would not happen until the following day.

At pages 7 and 8 of [their] second interview with this Investigation [Nurse C's] evidence was that if an instruction had been given to [them] and the [Nurse E] to get patients on trolleys out of the department on the night in question [they] would have no reason to not follow that instruction, concerned as [they were] about the overcrowded situation the Emergency Department (emphasis added):

So there would be no reason
that if an instruction was given that I would not say, you know, that is exactly what I am looking for is to get as many patients out of the department to make it safer for patients within the department and staff within the department. So if that instruction was given to [Nurse E] and then to me, I would have
no reason not to follow out that instruction, it would have been in my interest, in the staff and in the patients' interest to follow out that instruction.
That is what I looked for to happen so early in the night. We all know, you know, an overcrowded emergency department, the risk within it, you know, that is well documented and I am so aware of an overcrowded -- there is nothing normal about it. You know, the risk to patient safety within an overcrowded emergency department. And the one thing that I looked for to be done early was to try and decant the emergency department of as many patients as possible. For me looking for trolleys to go on wards at 10 o'clock, by 8 a.m. not one trolley went up.

And at pages 8 and 9 (emphasis added):

Q. Can I just read you what [Senior Staff Member A] said in interview with me, just so again you have an opportunity to comment on it. It is pages 22 and 23 of the stenographer's account of that interview.

A. Okay.

Q. [They] said: "I would have rung [first name of Nurse E]", that is [Nurse E]:
"...to say it was trolleys or to open the surge area and trolleys at ward level. I would have rung the [Title] in ED
..."
Which I think is yourself.
"... this is all after speaking to [Senior Staff Member B]. I
was very clear, and we had our 1 a.m. meeting as well, and that was trolleys at ward level but the information I was being given was that the patients didn't fit the criteria. My line to that is that you haven't patients that are suitable. You need to be able to account for that and document that."
Now, I take it you do not agree that that is an accurate account of what happened between say 10 and 1 a.m. on the following morning?

A. One hundred percent I do not agree with any of that. That was not reported back to me. I looked for the trolleys to go up and I was told they would not be going up overnight.

Q. Just so I am clear about who was telling what or whom, the person who told you that was [Senior Staff Member A]; is
that correct?

A. Correct.

[Nurse E's] response when [Senior Staff Member A's] account was put to [them] was (pages 10 and 11 transcript of Interview with [Nurse E] 22nd March 2024):

Q. Sure, sure, I understand that. That is something I will obviously have to raise with them. But so far as your recollection is concerned, it remains the same as you told me the last day. In other words if you had been given the go ahead to move patients, there were, we can't be sure of the exact number, but there was certainly a good number, upwards of 20 that could have been moved to wards if you had been given the go ahead to do it?

A. That remains my viewpoint, yeah.

[Nurse E] also pointed out in [their] second interview with this Investigation that [they were] the most junior manager on duty on the night in question in terms of the operational team, and at page 8 and 9 (emphasis added):

> In terms of the operational team I am the most junior manager out of them. There is CNM3CNM3, there is an operational and there is an exec. Had I gone ahead and just not followed a direct order, I can't see how I haven't faced any ramifications for that or indeed it wasn't put on the operational handover for that night, the [Senior Staff Member A] when [they] handed over in the morning or indeed it wasn't addressed at the telecon in the morning. You know, it is a very transparent handover that I have to give so I can't see how that hasn't come back to me until now.

For completeness, all sides to this issue were sent the appropriate relevant extracts from the interviews with those who had given contrary evidence to enable them to make any further observations if they wished. On behalf of [Nurse C] and [Nurse E], it was pointed out that it is of concern to them both that at no stage from December 2022 to the commencement of this Investigation in January 2024 did anybody in management raise the issue of an alleged failure to follow an instruction to move trolleys from the ED to wards on the night of the 17th December 2022 and they queried the credibility of such a serious omission going unaddressed in any way.

On behalf of [Nurse C], attention was drawn to the fact that [they] had contacted [Senior Staff Member A] twice over the course of [their] shift in respect of [their] concerns and had prepared and sent an Escalation Report to UHL managers at 6.19am on the 18th December 2022 suggesting that further measures needed to be taken. It is suggested on [their] behalf that it would be unlikely that [they] would have made that report if [they were] aware that there were instructions to move patients on trolleys to wards in circumstances where that instruction had not yet been carried out. [Nurse D] suggested that, in the case of [Nurse E], [they] had not been asked to give any account to the team complying the SAR report and was, therefore, only first asked to deal with these matters well over a year after the events in question.

None of the nurses from whom observations were sought in that regard departed from the accounts which they had already given to the investigation.

It thus follows that there is a stark conflict of evidence in this regard. On the one side, there is an account of a clear instruction being given with follow-up but trolleys were not moved to the wards and on the other side there is an equally clear account of it having been determined that no admitted patients on trolleys were going to the wards overnight despite two requests having been made for this action to be taken by [Nurse C]. There this matter rests. However, there are number of further matters which are at least relevant to this issue on which it is also necessary to comment at this stage.

(d) The Role of the Performance Management Improvement Unit (PMIU)

The PMIU (Performance Management Improvement Unit of the HSE) were involved with UHL during the summer of 2022. The principal period of activity occurred from July 2022 (4-6 weeks) with follow-up meetings from time to time over the following period. In evidence to the Investigation, the relevant representatives of the PMIU indicated that a particular focus of their efforts was to seek to assist UHL in the management of patient flow so as to minimise the extent to which patients might unnecessarily spend a longer period of time in the hospital than might have been required for their proper treatment. Clearly, this involves a matter of simple mathematics. The number of admitted patients in any hospital at any time is a function of the number of patients admitted and the length of time that each patient stays. Where the average stay of a patient is longer than that which is needed for their proper treatment, then, to that extent, the total number of patients present at any given time will exceed that which is required to give each patient proper treatment. In turn it follows that, to the extent that, consistent with proper patient care, the average length of time which each patient spends in the hospital can be reduced, this will lead to a proportional reduction in the total number of patients present at any given time with a consequent reduction on the pressure on beds.

While important in themselves, it is unnecessary for the purpose of the report to go into detail on the sort of measures which were implemented in conjunction with the visit and assistance of the PMIU. However, to take some simple examples, many patients require various tests and diagnostics to assist in their treatment. If such processes take longer than necessary then it is likely that the patient concerned will remain in hospital longer than required. The timing at which patients may be discharged can also have a similar effect. It would appear that many discharges took place later in the day so that vacated beds only became available at an even later stage. Earlier discharge would facilitate a more orderly allocation and utilisation of vacated beds.

In like manner there can be patients who have been approved for discharge by their consultant but where their actual departure is delayed because the conditions necessary to allow them to actually leave the hospital (such as, for example, a home package being put in place for those who may be discharged to their own homes or appropriate arrangements made in a step down facility for those who may be discharged to such a facility) are not in place. There is an account elsewhere in this Report of the effect of the measures adopted in conjunction with the PMIU on overcrowding in the ED. However, for the purposes of the current issue, a question arises as to the effect which the views of the PMIU had on the issue of admitted patients on trolleys being placed on wards.

There is no doubt but that, in an ideal world, it is undesirable that patients find themselves on trolleys on wards. Those patients do not have the same immediate facilities available as are present in respect of what might be called an “ordinary” bed on a ward. Likewise the presence of patients on trolleys has the potential to impair measures designed to improve patient flow. There is no doubt that one aim of the PMIU was to attempt to diminish the extent to which reliance was placed on admitted patients on trolleys being moved to wards as a means of dealing with the ordinary demand on beds in UHL. To the extent, for example, that patient flow could be improved so that the total number of patients present at any one time might be reduced then the need to place admitted patients on trolleys on wards would be reduced or, indeed, eliminated.

However, the issue which emerged in the course of the evidence before this Investigation concerned the question of whether, in substance, the PMIU had indicated that admitted patients should not, under any circumstances, be placed on trolleys on wards. A number of nursing witnesses gave evidence that it was their understanding that the PMIU had recommended against trolleys being placed on wards. However, not all of those nurses had themselves been involved in discussions with the PMIU but rather in some cases were indicating their understanding, from others, as to the position adopted by the PMIU. In addition it should be noted that, as a result of measures adopted in conjunction with the PMIU, it transpired that it proved possible not to place admitted patients on trolleys on wards for some period of months up until the 24th October 2022. However, on that date some patients were placed on wards because of the particularly high number of admitted patients for whom ordinary beds were not available on that occasion. When that occurred the INMO wrote to [Senior Staff Member C] in the following terms: -

"we refer to a
retrograde step taken by the University of Hospital
Limerick at the weekend to place additional patient

trolleys on corridors when a Review Group appointed by the HSE eradicated the practice from this hospital. The action taken this weekend by management is viewed as unsafe, counterproductive to the patient flow processes that were progressing well while the review team were on site for a shorter period of time".

In [their] evidence to this Investigation [Senior Staff Member A] referred to what [they] understood to be the position of the PMIU in the following terms (pages 7, 8, 9 and 10 transcript of Investigation Interview 4th March 2024) (emphasis added):-

Q. No, no, I appreciate that. But your understanding from your interaction with the PMIU personnel was -- could I just be clear exactly what it was, was that patients shouldn't go to wards at all?

A. On trolleys.

Q. On trolleys?

A. On trolleys, yeah.

Q. I can see why that was a concern to you. Before we leave the escalation issue, I just want to be clear were you personally at meetings that involved personnel from the PMIU where it was said that trolleys, boarded patients shouldn't be going to wards?

A. Yes, yeah.

Q. The impression you got, correct me if I am wrong, was that the PMIU were suggesting that there shouldn't be 1
trolleys, boarded patients on trolleys going into wards?

A. Yes and I think that is what created challenges, I suppose, for the operational office, you know, knowing that, you know, yes trolleys should have gone to ward areas based on the activity in ED to deescalate the ED and try and, you know, mitigate the risk across site as such. That was a challenging piece there, you know, because we didn't have a clear escalation then at that stage to say okay, if we have 20 boarded in ED then we escalate, we move to trolleys at ward areas so that was a grey area there then.

It followed, therefore, that there appeared to be an issue as to precisely what the PMIU had recommended. With that in mind the representatives of the PMIU who were part of the team which attended UHL were asked for their observations on this issue. In substance their account was consistent with the fact that they had,

indeed, recommended that measures be taken to attempt to reduce or eliminate the need for admitted patients to be placed on trolleys on wards and that the patient flow measures adopted should have led to such a situation.

However, the PMIU was equally clear that their advice did not suggest that patients should not be placed on trolleys on wards in circumstances where that was necessary, not as a matter of ordinary practice, but on occasions of particularly heavy numbers of patients awaiting beds. It should also be added that the PMIU made clear that they considered that other decongestion measures, such as the opening of surge facilities in wards not currently in use, should be adopted before placing trolleys on wards. However, the PMIU were clear that they accepted that, where appropriate patient flow measures together with the opening of appropriate surge facilities proved inadequate to release the strain on the number of admitted patients on trolleys in ED, then it was appropriate to relieve that strain by placing admitted patients on trolleys on wards. It was also the evidence of the PMIU that the sharing of the burden of dealing with such patients between ED and such wards as could accommodate a small number of additional patients on trolleys was the appropriate way to minimise the overall risk to patients. This approach was entirely consistent with the expert evidence given to me by Dr Doyle and Ms. Burns.

Obviously, in an ideal world, none of these measures would be necessary. However, where, for whatever reason, there is a significant excess in the number of patients who had been admitted and not yet actually discharged compared with the number of ordinary beds available, then those additional patients must go somewhere. All of the evidence presented to me suggest that, therefore, in appropriate cases, some of those patients may be required to be placed on trolleys on wards. The alternative is to create a greater overall risk by excessively overcrowding the ED.

In any event, the evidence of the PMIU was clear and to the effect that they had not indicated that it was inappropriate to place trolleys on wards in any circumstances. However, it was indicated that same should be only done where necessary and where the alternative, in effect, was to leave the Emergency Department excessively overcrowded.

In this context, it became important to discuss with the Senior Managers in UHL who were involved in meetings with the PMIU as to what their recollection was of the PMIU position. It would not appear that any formal written recommendations were made (although there are slides used at presentations) so that the position of the PMIU was set out at a variety of meetings with managers.

[Senior Staff Member D] told this Investigation that the first action mandated by the PMIU in the summer of 2022 was the removal of trolleys from the wards, an action which [they] objected to (page 42 Investigation Interview 8th May 2024) (emphasis added):

Regardless of what you have told to date by anyone else, <u>I can leave you in no doubt that the first action mandated, and I use the word mandated because it is a strong word, by the PMIU was to remove ward trolleys.</u> I can give you evidence of where that is stipulated in their presentations to us and evidence of where they willingly will show how ward trolleys went to zero very quickly after their intervention. I resisted that strongly. I clearly articulated to them when I met with them that the risk assessment undertaken by [Senior Staff Member F] on ward trolleys in the Emergency Department was a risk rating of 25 out of 25, the highest level it can be. The risk rating of a patient admitted on a trolley on a ward was an Amber 9. Despite that they still proceeded with the mandate to remove ward trolleys.

[Senior Staff Member E] was on leave when the PIMU were active in the hospital. [Senior Staff Member E] stated at interview that while [they] would prefer if there were no trolleys at ward level in UHL (page 55 Investigation Interview 8th May 2024):

.. but in UHL it is a release valve and it is a safety issue and I had it risk assessed many times. The risk is nine on a ward where it is 20 red in an ED. So you are going from Amber to Red so this is the situation."

[Their] evidence to this Investigation was that when [they] returned from leave in 2022 (page 55 Investigation interview):

The PMIU, I studied all the data when I came back when I got hand back and it is very clear there in presentations it is the first goal objective, remove ward trolleys. There is also graphs around it. There was a number of road shows with staff that I checked with my comms team, many many staff turned up and it was quite directive to remove ward trolleys and it was supported by the INMO and of course the ward staff, which again I understand from a ward staff perspective.

[Their] evidence was that when the activity level began to rise in the ED, [they] issued a directive to place patients on trolleys on wards (page 56 Investigation Interview, emphasis added):

As soon a I saw the activity rise in ED, some days there was 30 on trolleys from the date in October.
I issued the directive. The INMO objected strongly,

Those nurses, who had to make decisions on the ground, appear to have understood that the PMIU had cautioned against patients going to wards on trolleys. This appears to have been the understanding too of [Senior Staff Member D] and [Senior Staff Member E], albeit [Senior Staff Member D] refers to it as a mandate and [Senior Staff Member E] as an objective.

In light of the evidence of [Senior Staff Member D] to the effect that there was no confusion about this matter and of the evidence of [Senior Staff Member E] to the effect that [they] had issued a directive that trollies were to go to wards, the Investigation raised further queries on this issue. The fact remains that the evidence (including passages already cited) from Nurse Managers on the ground made reference to the fact that the PMIU recommendation/requirement/mandate concerning ward trollies remained an issue in December 2022.

[Senior Staff Member D] responded by email dated the 29th May 2024 deferring on this issue to [Senior Staff Member E] and stating that it would not be part of [their] function as [Senior Staff Member D] to provide an instruction to non-executive nursing personnel that moving trolleys to wards was approved by [Senior Staff Member E].

In [their] response [Senior Staff Member E] referred this Investigation to the minutes of meetings at which the issue of ward trollies was discussed. The first such meeting took place on 23rd October 2022 and is described as an "Extraordinary Executive Huddle". On this date there were 40 ED trolleys in use at 8am and no ward trolleys. Those attending included [Senior Staff Member G], [Senior Staff Member C], [Senior Staff Member D], [Senior Staff Member H], [Senior Staff Member B], [Dr H], [Senior Staff Member I] and [Senior Staff Member J]. This document records actions completed which includes "*One trolley to be placed on each ward with admitted patient from ED",* this is marked as *"completed"* and another action: *"[Senior Staff Member J] to inform wards that patients from ED will be placed on trolleys onwards"*...this is marked as *"completed".* [Senior Staff Member J's] communication is not included.

There is an email from [Administrative Support Staff A], to [Administrative Support Staff B], dated 24th October 2022 which refers to *"Directive from the A/CEO & HOS that an admitted patient is transferred to the wards where there is a confirmed discharge-8 trolleys on wards".*

Also included were minutes of DOSH meetings (Daily Operational Safety Huddle Notes) for the 25/10/2022 (being the day after ward trollies were first used after a period of their not being used for some months) and 4/11/2022. These minutes were emailed to a number of staff including [Senior Staff Member A] and [Senior Staff Member K]. There is, therefore, no question but that there was a discussion about the use of ward trollies at this time and it is also clear that ward trollies were being used to a material extent as a means of decongesting the Emergency Department.

However there does not seem to be evidence of a clear direction to Nurse Managers on the ground as to the various changes in policy which appear to have taken place.

[Senior Staff Member E's] evidence to this Investigation on the issuing of a directive in October 2022 that trolleys with admitted patients were to go to wards from the Emergency Department once the threshold was reached was put to [Nurse C] in [their] in [their] capacity as [Title] at the time.

[Nurse C], by email dated the 14th June 2024, responded with the following observation:

'In late October, as the winter surge began trolleys began to be moved again from ED to wards but this was not as a result of any directive formally communicated to us as operational managers. If there was a directive, we never got it. No meeting was called, no communication happened, certainly at my level. This change of practice just seemed to happen but on an ad hoc basis'.

A review of a spreadsheet provided by the PMIU setting out the figures for ward trolleys and ED trollies between 1st January 2022 and 17th April 2024 is instructive. This spreadsheet is annexed to this Report at Appendix 9.

It will be recalled, in that context, that the PMIU were on site in July 2022. Between the 19th of July and the 23rd of October, the spreadsheet suggests that no ward trollies were used. However, during that period, there appear to be approximately 44 days on which the number of ED trollies exceeded the protocol threshold of 23 so that, in accordance with the Decongestion Protocol, ward trollies might well have been used. It may be that, on some of those days, it was, or would have been, possible to alleviate the situation in ED without using ward trollies. The spreadsheet does not offer any information on that question. However it seems

abundantly clear on the evidence that the protocol was not operated during the period between the 19th July 2022 and the 23rd of October 2022 where there at least a significant number of days when the Protocol would have suggested that ward trollies be used.

It is next necessary to look at the period between 24th October 2022 (when ward trollies were again in use), and the period immediately before the events with which this Report is concerned. During that period, while there are regular instances of ward trollies being used, there seems to be approximately 10 to 12 days when, despite the protocol threshold of 23 ED trollies being exceeded, ward trollies were not used. It may again be the case that, on some of those days, other measures may have been taken to bring the number of trollies in the ED below 23 without the need to deploy ward trollies. However, this analysis suggests that, while a decision had clearly been made to again use ward trollies on occasion, the full operation of the protocol may not have been universally applied.

This situation would have given credence to the impression that the PMIU had adopted a position which either, on one view, recommended against the use of ward trollies or, on another view, mandated that they not be used at all. The evidence supports the view that a decision was made at senior level, in late October 2022, to go back to the use of ward trollies in accordance with the protocol. It would also have been clear to all those involved that ward trollies were, in fact, being utilised on at least some occasions. It follows that the evidence supports the view that Senior Managers went along, in some cases quite reluctantly, with the position of the PMIU up and until the latter part of October 2022 but decided at that time, to reverse the position and go back to the use of ward trollies in accordance with the Protocol in that regard. While that position is undoubtedly clear on the evidence, it is not at all clear that this formal position of adopting and later reversing the PMIU position had been fully communicated to Nurse Managers on the ground and that the reversal of policy was being fully implemented.

In that context, [Senior Staff Member A], who was on duty on the 17th December 2022 said in [their] evidence to this Investigation (pages 6 and 7) said on the issue of escalation and trolleys going to wards (emphasis added):

It is quite challenging in that it depends on the Exec that you have on call, you know, whether trolleys go to ward areas, boarded patients go to ward areas, whether we open the surge areas, extra capacity. I suppose with the PMIU coming in July, that also affected decisions being made, I suppose looking at whether

trolleys went to ward areas or not. September there was zero, October there was zero. You know, there were some elements of trolleys going up in November and I suppose 23 out of 31 days trolleys went up to ward areas in December. So it wasn't consistent, it was depending -- it was dependent on the Exec on call really.

[Senior Staff Member A] also stated (pages 7 and 8 Investigation Interview):

But your understanding from
your interaction with the PMIU personnel was -- could I just be clear exactly what it was, was that patients shouldn't go to wards at all?

A. On trolleys.

Q. On trolleys?

A. On trolleys, yeah.

At [their] interview with this Investigation [Senior Staff Member K] page 6: acknowledged that trolleys were going to wards end of 2022 and said (emphasis added):

In December that year, including up
to the 31st December we had about 23 times trolleys went up because it got busier but we were still discouraged in putting up trolleys.

As regards the PMIU [Senior Staff Member K] gave evidence (page 9):

I am aware that the PMIU were involved over that period. But could I just nail down, so far as you were concerned where did the information come to you that they were, I think to use your own phrase, discouraging trolleys being put on wards?
A. From the CDON to the Directors of Nursing down to the ADONS, it came down the channel.

At page 10 of [their] transcript this Investigation asked [Senior Staff Member K] about [their] evidence to the previous review which led to the SAR Report that trollies were not going up to wards because of the unions (emphasis added):

There was just a phrase that I think you used in your interview, you said, it is on page 17 of the transcript:
"No because we didn't put up trolleys because the unions had been in before and we weren't putting up

trolleys at that point at all."
Could you just elaborate on what you meant by that?

A. That was along with the PMI Unit, the unions had, you know what I mean, that is why the PMI unit came down. Like they are trying to protect the staff on the wards, you know, it is all working together.

Q. Sure. So it was both the PMIU and the unions were discouraging if you like?

A. Yes because the staff went to unions because they were getting these extra trolleys up which meant they were having extra work to do.

The minutes of the meetings earlier referred to also make clear that there were those who raised safety concerns regarding the escalation plan for admitted patients in ED. That is consistent with the position adopted by the INMO in the letter to which reference has already been made.

In that context it is important to make a distinction between two different sorts of situation. The view of Senior Managers in UHL was to the effect that the risk to patients on ward trollies was significantly less than the risk of the same patient being on a trolley in ED. Reference has already been made to the evidence of [Senior Staff Member D] and [Senior Staff Member E] in that regard. That might be described as a more general question as to whether ward trollies were a safer option in circumstances where patients had to be on trollies somewhere within the hospital.

However there is a more specific question which arises in the context of the decongestion protocol. That issue concerns whether, whatever may be the situation that applies generally, it can be said that there is a greater risk to patients being on trollies in an overcrowded ED, on the one hand, as opposed to being on ward trollies, on the other. In other words, the distinction is between whether ward trollies are safer in any event, or whether they are at least safer where the alternative is to leave patients in a significantly overcrowded ED.

Having regard to the observations made at the meetings to which reference has been made above and the relevant letter from the INMO, the Investigation wrote to the INMO with a view to ensuring that their position was fully and fairly set out in this Report. That letter drew specific attention to the distinction just made between the use of ward trollies generally, on the one hand and the use of ward trollies in circumstances of an overcrowded ED, on the other. The response of the INMO dated 12th June 2024 was as follows:-

"The INMO is an independent professional Trade Union. We negotiate agreements regarding patient flow at a national level with the HSE and participate in their implementation at a local level. When it is reported to us by our members that the agreement is not being implemented – we raise this with management at the hospital level. The current national agreement (attached for ease of reference) – sets out the need to de-escalate overcrowded wards. It is a matter of consensus that trolleys on inpatient wards are not the solution to ED overcrowding, the evidence is that when hospitals move to stage 3, of the escalations protocol, this must be managed in a standard way as set out with a follow-on de-escalation plan.

While the INMO did not agree to the Full Capacity Protocol in the 2016 WRC proposals, these proposals were accepted by ballot of members, and it is a matter of fact that the Full Capacity Protocol has been implemented in many hospitals including University Hospital Limerick since 2016. The INMO has seen positive outcomes in many acute hospitals where this escalation plan is implemented consistently and in a planned way e.g. Waterford University Hospital, Beaumont Hospital, Connolly Hospital. Our criticism of the approach taken in University Hospital Limerick is that the use of trolleys was a constant feature without implementing all steps in the escalation protocol and without any de-escalation plan. Therefore, it is this practice that was and is objectionable. Furthermore, the HSE policy at stage 3 provided for, as a step in the escalation process, the placement of additional trolleys/beds on each inpatient ward, and the INMO did not in our correspondence dated 25th of October 2022 threaten or object to the HSE utilising this policy appropriately. Where there is a major surge of activity and excessive overcrowding there is a system wide escalation policy in place of which trolleys on wards is one part only of step 3 (page 9 of System Wide Escalation Framework and Procedures). In addition we would have expected the HSE national major incident protocol to be implemented by management on these occasions."

The INMO made the point that it is their view that once the expert review team was not present *"old habits returned, with a lack of adherence to the escalation framework leading to constant overcrowding throughout the hospital which remains the situation today.."* and that as a professional Trade Union, the INMO is obliged to raise matters of concern to its members particularly concerning *"poor oversight or non-adherence to agreements brokered with management".*

Ultimately the position seems to be that there remained in place at all material times a clear protocol requiring the use of ward trollies when certain thresholds were met. However a decision was made not to operate that protocol for a period as a result of the intervention of the PMIU in the summer of 2022 with a

subsequent decision in late October 2022 to reverse that position and go back to the operation of the protocol.

The evidence does not suggest that there was clear communication to nurse managers on the ground as to that revised policy. This is an issue raised by this Investigation with Senior Managers and is referred to in Chapter 9 in that context.

(e) A Second Conflict of Evidence

In the context of the trolleys question, a potential additional factual issue arose in the course of evidence concerning whether or not there had been any interaction with [Senior Staff Member C] on this question on the evening of December 17th 2022. In the course of [their] interview with the Investigation, [Senior Staff Member A] indicated that [they] had had a limited interaction in that regard. On [their] account, in the course of a telephone conversation relating to other matters, [they] did refer [Senior Staff Member C] to the question of trolleys going on wards. [Senior Staff Member A] stated at page 24 of the transcript of [their] Investigation Interview.

Q. The other thing, did I read somewhere there was some contact was it with [Senior Staff Member C]?

A. [Senior Staff Member C] for just to check on a colleague really and I discussed the situation in the department. I discussed around the surge area opening and trolleys to go to ward areas. I suppose [their] concern was what was the release valve the following day if we put a round of trolleys up overnight but that was only a general discussion. The discussion with [Senior Staff Member B] was trolleys, we will run around with trolleys and
open surge, which is the surge in the day ward

However, when [Senior Staff Member C] was interviewed by this Investigation on the 29th April 2024, while agreeing that [they] had the relevant unrelated conversation with [Senior Staff Member A], [they were] clear that there had been no interaction in respect of the trolleys question (pages 37 and 38 transcript of Investigation Interview):

Q. We know, in fact, it didn't happen. The opening of the surge facility did happen but the trolleys on wards didn't. Had you any involvement in any decision making around that personally?

A. I had no input at all in those decisions, no.

Q. Had you any discussions with anyone about it?

A. On the night in question, no.

Q. Yeah, on the night in question?

A. No, I had no discussion in relation to ward trolleys or surge plans on the night in question.

Q. Sure, I don't need to know the detail of that. Did anyone say anything to you about the fact it was fairly overcrowded on that occasion?

A. There was no reference to any Category 2s, 3s. It was nearly -- I suppose it is busy and ED is always busy. But there was no minutiae in relation to the extent to which how busy it was.

In light of that apparent difference of recollection, both [Senior Staff Member C] and [Senior Staff Member A] were written to and their attention was drawn to the potentially differing accounts on the matter which they had given to the Investigation.

[Senior Staff Member C] responded by email dated the 8th May 2024 stating that the purpose of the call which was initiated by [them] related to a ██████ matter and that while [Senior Staff Member A] did refer to the fact that the ED was busy

"there was no details pertaining to trolleys, surge capacity, or decongestion measures discussed. It is further the case that there was no discussion pertaining to the numbers of patients triaged as being within the various Manchester System categories. Had my advice been sought on the management of these matters in the course if this conversation I would have provided it, however, it was not." (emphasis added)

[Senior Staff Member A] responded by email on the 11th May 2024, and after setting out the plan [they] agreed with [Senior Staff Member B] to deal with the overcrowding in the ED including the opening of the Surgical Day Ward (capped at 7 beds) and the placing of one round of admitted patients on trolleys to ward areas, stated (emphasis added):

"Management plans on the night were clearly communicated by myself to [Senior Staff Member C]."

In a further email dated the 28th May 2024 to this Investigation [Senior Staff Member A] stated

"Of note when I advised [Senior Staff Member C] that I planned on opening Surge and placing one round of trolley's at ward level, with regards to the trolley's [they] did ask "what was the release valve for tomorrow" (Sunday) if this occurred but to follow up with a discussion with [Senior Staff Member B]."

That observation also raises a question, to which it will be necessary to refer elsewhere in this Report, as to the relative roles of [Senior Staff Member A] on the one hand, and [Senior Staff Member B], on the other concerning the implementation of de-escalation measures.

When the potential conflict of evidence between [Senior Staff Member A] and [Senior Staff Member C] was put again to them by sending them a draft of the proposed section of this report dealing with that question, [Senior Staff Member A] reiterated [their] position. [Senior Staff Member C] denied that [they] posed the question "what was the release valve for tomorrow". [They] reiterated [their] previous evidence to the investigation and did note that [they] "did provide an instruction for trolleys to go wards the following morning" when [they were] appraised of the situation. The conflict of evidence, therefore, remains and is of some importance having regard to the fact that, on [Senior Staff Member A's] account, [Senior Staff Member C] was, at least to a limited extent, appraised of the situation the previous evening and informed that there had been a decision reached, subsequent to the discussion between [Senior Staff Member A] and [Senior Staff Member B] for trolleys to go the wards.

There remains, therefore, a conflict between [Senior Staff Member A] and [Senior Staff Member C] as to [Senior Staff Member C's] knowledge of the situation in the Emergency Department and the plans put in place to deal with the surge, including the placing of admitted patients on trolleys on the wards, on the night in question.

It is next necessary to turn to the x-ray issue.

5.2 The X-Ray Issue

As noted earlier, one of the issues of fact that emerged relates to the circumstances in which Aoife had an x-ray taken early on the morning of Sunday December 18th. When interviewed by me, a point was made by the family's solicitor that circumstances surrounding that x-ray provided an occasion when attention might properly have been drawn to Aoife's worsening condition. On that basis it was said to be one of a number of opportunities which were missed which could have led to Aoife being treated earlier with obvious consequences for the prospects of a better outcome.

As already noted, the SAR Report had dealt with this matter although it had suggested that no x-ray was in fact taken. The details in respect of both "arrival" of the x-ray request and the timing of the taking of the x-ray itself are also set out earlier.

[Dr D] did give evidence both of ordering the x-ray concerned and of the fact that, in [their] recollection, porters arrived to bring Aoife to the x-ray department in circumstances where those porters were, apparently, unhappy that it was said that she did not feel in a position to go with them. [Dr D] stated, page 18 of [their] Investigation Interview transcript:

Yeah, so generally with patients where there is no obvious source or where you are trying to find a source of, say, sepsis, you would do bloods, blood cultures, urine, chest x-ray to find a source. So as the routine part of the work up I ordered a chest x-ray. When the porters came to fetch her for the chest x-ray, mum said she didn't feel up to it, can they wait a little bit and the porters said fine. So the chest x-ray when I was still there, I didn't get to see the chest x-ray, I am not sure if it was done.

And at page 19:

I think as I was leaving the room I do remember hearing mum say that she didn't feel up to it, could you wait and the porters I think were slightly annoyed to be honest because they had come all the way to fetch her and then she said no. So that is the interaction I recall.

Evidence was also obtained from [Health and Social Care Professional Staff Member A]. [They] indicated that the normal practice was that there was a Health Care Assistant assigned to the Radiography Department who would be tasked with bringing patients, who required an x-ray, from the ED to x-ray. The two locations are, in fact, very close together. However, in the recollection of [Health and Social Care Professional Staff Member A], [Health Care Support Staff Member A] was on a coffee break when the request for an x-ray for Aoife came in and, therefore, porters were asked to collect her instead.

In the circumstances [Health and Social Care Professional Staff Member A] gave evidence that Aoife did not come back with the porters and, sometime later, [Health Care Support Staff Member A] did bring Aoife in a wheelchair from the ED for her x-ray. The records suggest that the x-ray request "arrived" at 5:53. On the

evidence this seems to refer to the fact that the request by a doctor for an x-ray arrives electronically in the x-ray system and does not suggest that the individual who was to have the x-ray taken had actually arrived in the x-ray department. The x-ray itself appears to have been taken at 7:05 so that the record suggests that there was a gap of well over one hour between the request being made and the x-ray actually being taken. It does not appear that there were a very large number of x-rays to be taken on the occasion in question which fact might have explained such a delay being simply caused by the number of patients awaiting the procedure. On that basis the delay is consistent with the fact that there was an initial difficultly, of whatever type, with Aoife attending for x-ray. Finally it should be said that [Health and Social Care Professional Staff Member A] added that Aoife was able to stand for the x-ray but that she was “wobbly”.

The evidence that had been accumulated from the hospital at this stage was sent to the solicitors for the family for their observations. In addition it was determined that it would be appropriate to seek to interview the porters concerned (if they could be traced) and [Health Care Support Staff Member A].

The family’s solicitors responded by letter dated the 30th April 2024 which is annexed at [**Appendix 10].**

This Investigation made enquires of all porters who were on duty on the morning in question and those individuals have no recollection of events on the morning of the 18th December as they pertain to Aoife.

A synopsis of the evidence of [Health Care Support Staff Member A] is set out in the chronology section of Chapter 4.

Mr and Mrs Johnston are adamant that they did not advise any porter that Aoife did not feel up to going for the x-ray. Their position is that they interacted with a female who came to take Aoife for the x-ray. Mr and Mrs Johnston’s solicitor advises that Aoife’s parents were told that they were not needed when they asked to accompany Aoife to the x-ray. Mr and Mrs Johnston have instructed their solicitor that this interaction happened before Aoife was seen by a doctor.

The solicitors in their correspondence of the 30th April 2024 also stated that the x-ray concerned was not included in the bundle of records received from the hospital. It was also pointed out that [Health and Social Care Professional Staff Member A] at interview advised that Aoife was relatively well and stood up for the chest x-ray while the evidence at the Inquest was that from approximately 2.30am on the 18th December Aoife was not able to go to the toilet without the assistance of a wheelchair.

In light of the indication by the family's solicitors that the family had not received Aoife's x-ray this Investigation by email dated the 7th May 2024 contacted the office of the CEO of UL Hospitals Group ("CEO ULHG") and asked that Aoife's x-ray be sent to the family's solicitor. The office of the CEO replied by email dated the 8th May 2024 indicating that clarity had been sought as to which x-ray the solicitors were seeking as the hospital had, it was said, previously provided the 3 x-rays that were completed. Aoife's x-ray was provided to this Investigation. The hospital responded to a request by this Investigation that the x-ray also be provided to Aoife's family's solicitors indicating that they were happy to provide it once the request was made by the solicitors in line with FOI.

On providing the family's solicitor with the proposed section of this Report dealing with this issue, it was pointed out that the Johnston family's legal team had received a chest x-ray report for Aoife dated 18th December 2022 which referred to the x-ray taken at 7.09am. This document states *"Indication: Post Intubation".* The expert assisting the Investigation, Dr Doyle, reviewed the notes and suggested that Aoife was intubated between 10.43am and 10.48am on the 18th December 2022 and that the indication concerning intubation for the x-ray taken at 7.09am on the 18th December was incorrect. Aoife was not intubated at that time.

A further query was raised by the Investigation with the hospital. The email response dated the 8th July 2024 confirmed that chest x-rays were ordered for Aoife at 5.51am, 12.03pm and 21.28pm on the 18th December 2022. The hospital confirmed that Aoife was intubated at approximately 10.45am on the 18th December 2022.

The response from the hospital was sent to the Johnston family's solicitor as was the draft section of this report dealing with this conflict. Their observations were received by the Investigation on the 10th July 2024.

The family are not at all satisfied with the response from the hospital and believe that they have not been provided with an x-ray which on their account was taken in the earlier hours of the morning. They dispute the account of [Health Care Support Staff Member A] who took Aoife for x-ray at 7.09am, suggesting that Aoife was slipping off the trolley by that time and that her father was unable to hold her.

Mrs Johnston says that Aoife was wearing a red "snoodie" when she returned from x-ray and that this was removed by a nurse at some point during the night to in an effort to bring down Aoife's temperature. The

Johnston family are adamant that Aoife went for an x-ray early in the morning before seeing a doctor and that the time provided by the hospital for the x-ray is incorrect. They believe that this was another lost opportunity for Aoife's care to be escalated. It is clear that this issue is a source of great distress to the family. This Investigation cannot, regrettably, resolve this conflict. It is unfortunate that the x-ray records provided are inaccurate, which seems to be accepted by the hospital, and it would be appropriate for the hospital to provide an explanation to the Johnston family for this.

Before leaving the question of the X-ray issue, it is necessary to refer to a complaint made on behalf of Aoife's parents to the effect that they were not involved in any way in the finalisation of the SAR report. It will be recalled that certain Senior Managers were shown a draft of that Report and then interviewed in the context of what was described as Quality Control. No such facility was afforded to the family or their representatives. It has been confirmed on behalf of the CEO of the HSE that it is within my Terms of Reference to comment on this matter.

Whatever may be the merits of involving those who may have suffered as a result of an incident (or their relatives where there has been a tragic outcome) in a Review, the fact that Aoife's parents were themselves directly involved in some of the issues does suggest that it would have been more appropriate that they would have been at least given an opportunity to comment on those aspects of the Report which directly involved them. The X-ray issues which emerged during the course of this Investigation might well have been clarified at an earlier stage had that facility been granted.

5.3 The Doctors Issues

There are a number of differences in recollection between the accounts given by, on the one hand, nurses, and, on the other hand, doctors, and, indeed, in one instance between doctors, concerning some of the events on the occasion in question.

The first issue concerns the extent to which the Registrar assigned to the zones was actually working in the Resus area for some of the night shift.

[Dr D] gave evidence at page 5 of [their] Investigation Interview:-

Q. So was it fair to say that a lot of the time both registrars were in the Resus?

Yeah, the only time I really recall seeing one of the registrars
the whole night was when I, in passing, just after I had been into the room to see Aoife, I came out, I was having a quick look at the antibiotic guidelines on the computer and I was starting to write down her notes and I just mentioned something about her to [them] in passing, and that is the only time I can recall seeing any registrars at that time of night. Because they were in Resus the whole time?

A. They were in Resus yeah, they were busy.

However, [Dr B]'s position is that [they were] the Registrar assigned for the zones and Paediatrics and that [they were] for the majority of [their] shift in those areas apart from a couple of hours when [they] assisted in Resus and then returned to the area to which [they were] primarily assigned (page 4 of [their] interview).

Q. As in between the zones and the paediatrics, have you any recollection of were you spending more time in paediatrics or more in the zones?

A. Because we had assigned [Dr D] to look after in Zone A, because that was where all of the action was going on for that night, as far as I can recall we were okay with the other two zones, say Zone B and C were okay. But I was moving between Zone A and looking after the paediatric patients that night.

Q. Okay?

A. But for some time I had to move out to help in the Resus, which I did for a couple of hours and then I came back to where I was assigned primarily.

There is, therefore, something of a difference between those two doctors as to the extent to which there actually was a Registrar working in the zones for a significant portion of the shift. It is agreed that the Registrar in question did work in Resus for a period but [they put] that period as being much shorter than the account given by [Dr D].

In the same context it is worth noting that the reason given by [Dr B] for going in to Resus was [their] own estimation of the situation in Resus. When asked how [their] going into Resus came about [Dr B], in response to Dr Doyle, page 19 Investigation Interview (emphasis added):

what happened was because, as I said, we would have the white board in front of us and
we could see as to what is the number of patients that

are in the Resus at a particular point in time. So it was totally my decision and that is what I did is I just went in and I asked them if there is anything I could do to help relieve the patient load or if there is anybody who could be moved out, if they need some manipulation or anything at all. What I was told by one of the nurses in the Resus was that there were three neck of femur fractures who had been waiting on getting a block. So I called [Dr I]down to the Resus and I said to them we have three neck of femur fractures so if I deal with them while [Dr C], [they are] dealing with the rest of the emergencies, I think there were two STEMI calls or whatever was coming through the door that night. That was an understanding between myself and [Dr J] for me to go in and help to phase out the three patients in question.
Q. Okay. So as far as you could see, looking at the totality of what was happening in the department, you felt this was something that was a priority for you to do?
A. It was because at that point in time what I could see was in our seven bay Resus there were upwards of 15 or 16 patients. I mean in addition to the 7 bays there were maybe 9 patients out around the -- I mean around the corridor in the Resus. So that is what I thought. I mean that is what I thought, even if one of them is -- all I needed was I just needed one cubicle to help with those three patients and that is what I did, I got one cubicle and I was able to block the three of them and get them moving.

It does not appear on [Dr B]'s evidence that there was any general discussion about whether [they] would be better deployed in the zones or in Resus but rather it appears to be a decision [they] took on [their] own having regard to [their] assessment of the undoubtedly difficult circumstances that applied in the department on the night in question.

In accordance with the procedures adopted by the Investigation, a draft of that portion of this report, which deals with the difference of recollections between [Dr D] and [Dr B] concerning the extent to which [Dr B] was in Resus during the night shift, was sent to the doctors concerned. [Dr D] clarified that, because [they were] under great pressure having regard to the very large number of patients to be seen, [they] had, as [they] put it, "put [their] head down" for much of [their] shift. While there is, therefore, a remaining difference of recollection between the two doctors concerned, it may well be explicable by the fact that neither doctor was focused during that shift on anything other than the very large number of patients who were categorised within Category 2 and who were awaiting being seen by one or other of them.

It is worth noting that, had there been a greater awareness of the sepsis risk associated with Aoife, different considerations might have applied at that time. However, for reasons elsewhere analysed, it does not appear that the nurses or doctors on the ground had any awareness of that situation.

Finally, there is a difference of recollection as to what exactly passed between [Nurse B] on the evening in question, and various doctors to whose attention Aoife's case was brought. It does appear, on the evidence, that Aoife's case was brought to the attention of [Dr A] shortly before [their] shift was due to end at 10.00pm in that [they] did prescribe certain drugs which were administered at that time. However it was not suggested that [Dr A] was asked, at that time, to see Aoife and it does appear that [they] prescribed the drugs in question without seeing her. [Dr A] at [their] Interview gave evidence (pages 14 and 15) that [they] had reviewed the notes and had prescribed medications for Aoife explaining that:

I just remember because when I get the notes I found out I have charted the treatment for her, just the fluids and paracetamol and I think that was that Zofran, ondansetron. Then after the notes, I have chart with a signature of mine. This normally happens because when the nurses are seeing, triaging the patient and the patient complained with symptomatic treatment like somebody have a headache or a flu or cough or temperature, saying he needs some fluids, he looks dehydrated so we start them with fluids, feel nauseous, we given ondansetron, makes sure the CG is okay. So like symptomatic treatment we start straight away so the patient who is waiting, they can have some treatment and might feel improved until being seen by doctor basically.

According to the medical records provided by UHL Zofran was given to Aoife at 20.25. The relevant record is annexed to this Report at **Appendix 5**. [Dr A] was clear in [their] evidence that [they] knew from reviewing the records that [they] wrote a prescription for Aoife but had no particular memory of that event on that evening (page 15 Investigation Interview).

Aoife was, on [Nurse B]'s evidence, feeling nauseated and vomited at 23.50 and medication was sought and prescribed for her. [Nurse B] did not ask the prescribing doctor to see Aoife at this time.

However, [Nurse B]'s account does suggest that, on two subsequent occasions, when [they] did bring Aoife's situation to the attention of Registrars, [they were] told that the doctors in question had not the time to see Aoife because of the large number of acute patients whom they were required to treat. The doctors in

question indicated that they had no recollection of being asked to see Aoife. A draft of the proposed section of this report dealing with this issue was sent to each of the persons concerned. No materially further information or observations emerged from that process. There that conflict must rest.

It is, however, worth commenting that, here again, it is likely that the situation may well have been affected by the lack of knowledge of all concerned of the sepsis risk which had been identified in respect of Aoife. That seems to me to be particularly important in the context of the fact that the prescription of the relevant treatment for sepsis is unlikely to be time consuming not least in comparison with some of the difficult situations which were facing doctors in the context of patients presenting with significant fractures or other acute conditions.

While not a conflict of evidence at all, it is also worth noting that [Nurse A] could not recall the identity of the Registrar who advised that Aoife should not go to Resus because it was so overcrowded (page 13 Investigation Interview).

[Nurse A] gave evidence at Day 1 of the Inquest into Aoife’s death that when triaging Aoife [they] did an ECG and had it signed by a Registrar whose name [they] could not remember (page 75 Inquest Transcript Day 1).

At Day 2 of the Inquest [Dr A] confirmed that [they] signed Aoife’s ECG (page 56 of the transcript). [They] did not recall being asked by [Nurse A] as to whether Aoife could be brought to Resus (page 57 and 58 Inquest transcript Day 2).

Having dealt with the conflicts of evidence which emerged during the course of the Investigation, it is next appropriate to turn to the issues which arise and which, at least in most cases, do so independent of the resolution of those issues of fact.

CHAPTER 6 - ISSUES ARISING

6.1. Monitoring of Patients

As noted earlier one of the issues for consideration, which was notified to Senior Management prior to their interviews, was the question of whether there were adequate processes in place to ensure proper follow-up in respect of patients triaged as Manchester Category 2 with suspected sepsis particularly where that patient was not sent to the Resus area and where there was a very limited number of both doctor and nurse availability in the ED Zones outside of Resus. Most of the underlying facts which gave rise to that issue do not appear to be in dispute on the evidence.

First it should be said that all of the evidence suggests that the normal practice is that a patient who is suspected of sepsis and who displays certain clinical signs consistent with such a possibility, would be placed in the Resus area. This was confirmed by [Dr F]. [Dr F], who in interview said:- "(page 28 of [their] Investigation Interview, emphasis added)

This was a sepsis patient, had systemic inflammatory response syndrome criteria and had some organ dysfunction, the blood pressure was low, so she was in septic shock when she came in and she needed to be -- the only place she needed to be in the Emergency Department was the Resus Room but at the time it was over census. It was full and there was patients on top waiting for –

Q. There was as many outside as inside as I understand it?

A. Yeah. So the Resus Room had burst as the seams already so the decision was made that the patient could only go to Zone A which is an ambulant area of the Emergency Department.

Similarly [Nurse A] indicated that, in light of the fact that Aoife had been referred to the ED by a GP with suspected sepsis and had been assessed by [them], in [their] capacity as [Title], as likewise suspected of sepsis, this would have meant that she would have ordinarily been placed in the Resus area.

The evidence also suggests that the only reason why Aoife was not placed in the Resus area was because that area was already very significantly overcrowded. The Resus area contains 7 cubicles. On the occasion in question there were at least 14 patients who had been placed in Resus so that there were at least as many again placed on trolleys in the vicinity awaiting treatment when space became available. In those circumstances [Nurse A] gave evidence that [they were] advised by a registrar that Aoife should not go into

Resus but was to be placed in zone A on the basis that she was "ambulatory" being that she was at that stage capable of walking.

It is also clear that there would have been no difficulty, had Aoife been seen by a doctor in Zone A, in her being administered the sepsis bundle. The problem, of course, was that, in order for that sepsis bundle to be administered, Aoife had to be seen by doctor who would have had the authority to prescribe the drugs in question. As we know, tragically, that did not happen for 11 hours after Aoife arrived in Zone A, with it taking over a further hour before the sepsis bundle was actually administered.

Before looking at this issue in more detail, it is important to record a small number of observations. First, as was pointed out by [Dr F], all patients who are triaged as Manchester Category 2 are, by definition, quite ill. While the focus of this Investigation is, understandably, on the proper pathway for patients who may be suspected of having sepsis and who may display clinical signs consistent with that condition, sight should not be lost of the fact that there are other suspected conditions which also require urgent attention. It is important to avoid the risk of solving the last problem at the expense of failing to take adequate steps to address the next problem.

Second it should be noted that one of the important recommendations of the SAR Report was that there should be a designated location within the ED in which patients who require a particular level of observation could be placed[11]. The purpose of this recommendation was, as I understand it, designed to relieve pressure on the Resus area so that patients who no longer needed to be in Resus, but who require a particular level of observation, could be placed in an area where that higher level of observation could be made available. Likewise, it would appear that such an area could be used in the case of a patient such as Aoife, who might ordinarily might be expected to go into the Resus area but who could not do so because that area was already overcrowded.

[Senior Staff Member G], at interview stated that the hospital was in the process of putting this facility in place (page 39 Investigation Interview). However, [Dr F] when interviewed by this Investigation stated that the observation room has not been provided as yet:

> Maybe the end of the year but there is a query mark around that. I haven't got any fixed date on that. I think there is a tender process still live on that.

[11] SAR Report, Page 51

[Dr K], who is now in the post of [Title] suggested 3 or so months for completion of this observation facility when this Investigation visited the ED on the 10th May 2024.

In advance of completing this Report, this Investigation sought clarification from [Senior Staff Member G], who by email dated the 22nd May 2024 stated that the works are due to commence on the 24th June 2024. [They have] been advised that these works will take 4 weeks to complete onsite.

This facility can only operate if the beds in it are adequately staffed and the risk of it being used for other purposes, if overcrowding persists, remains a concern as identified by [Dr F] at interview. With this in mind this Investigation sought clarification from [Senior Staff Member G] as to whether additional nursing and healthcare assistant staffing has been approved for allocation to the new observation area. [Senior Staff Member G] responded that [Senior Staff Member C] has advised that the staffing of this area is currently included in the Safer Staffing for the Emergency Department Review which review will include up to date ED attendance figures. According to [Senior Staff Member G] [Senior Staff Member C] plans to redeploy resources from other areas in the hospital until Safer Staffing is in place. The Investigation asked when the hospital expects the Safer Staffing review to be complete. The Investigation was informed by email dated the 11th June 2024 that the Safer Staffing review in the ED is ongoing with the National Lead for Safer Staffing. The review recommendations will be submitted to the estimates process once the review is complete.

Next, it is also important to mention another recommendation of the SAR Report[12]. This involved the adoption of a form of protocol in respect of the monitoring of patients, including such patients being re-triaged where there was objective clinical reasons for reassessing the urgency of their condition. [Dr F] at interview detailed that the Emergency Medicine Early Warning Score ("EMEWS") was rolled out in January of this year and involves patients who have been triaged and are waiting to see a doctor in the ED in UHL being re-triaged by a nurse dedicated to re-triaging waiting patients and giving an early warning score. [Senior Staff Member D] at interview also referenced EMEWS being in place.

This Investigation understands that UHL was one of the first hospitals to put in place the EMEWS system. In addition, [Dr K], told this Investigation that the EMEWS system had already identified a number of cases which allowed urgent attention to be given to patients in particular need. It also needs to be said that the

[12] SAR Report, Page 51

operation of the EMEWS system does require additional dedicated nursing staff. It follows that such a system could not have been put in place in December 2022 and, in reality, required the presence of the additional nursing staff whose recruitment was permitted under the Safer Staffing regime before it could be rolled out. The absence of such a system in December 2022 cannot, therefore, be blamed on UHL. However that does not take away from the fact that the system, if one could call it that, which operated at the time was an extremely ad hoc one.

The situation was really one where reliance was placed on individual nurses to seek the intervention of doctors where they had particular concerns about the condition of individual patients. In the context of the events of the 17th and 18th December, it is important first to note that the number of nurses in ED was 5 below its full compliment. That fact also needs to be seen in light of the decision made some months earlier which suggested that, on foot of the appropriate criteria (the National Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland 2022), 21.6 Whole Time Equivalent nurses had been approved but were not yet in place. The figure of 21.6 WTE is quoted in the SAR Report [13]. [Senior Staff Member C], referred to a figure of 21.5 WTE at page 17 of [their] Investigation interview. [Senior Staff Member C] gave evidence to this Investigation (page 12 and 13 Investigation interview) that while sanction had been given for the recruitment of those additional nurses, the process of actually having nurses working in ED took between 15 and 18 months so that none of the additional sanctioned nurses were actually working as of December 2022.

Thus there was a situation where it had been determined that the ED needed a significant uplift in the total number of nurses but where even the lower number, which had been calculated as being significantly under that required for safe staffing, was not met on the occasion in question by reason of there being 5 absences. This meant that the burden on individual nurses was far greater than had been assessed as being reasonable, and indeed required for safety. This in turn had very practical consequences. For example [Nurse C] gave an account of having to work as an "ordinary" nurse in the Resus area for a period simply because there were not enough nurses to attend in that area at certain times. This meant that the level of overall management of the ED, which would normally fall to the CNM2 on duty, was impaired because of the overall lack of nurses meant that [Title] had to do work which would ordinarily be done by staff nurses.

[13] Page 26 SAR Report

It follows that the ability of individual nurses to assess and articulate issues surrounding particular patients was undoubtedly impaired partly because of the general severe overcrowding in the ED on the occasion in question, exacerbated by the inadequate number of nurses working.

Notwithstanding this, [Nurse B] did seek to advocate on behalf of Aoife that she might be seen earlier than would have been determined by her place in the queue.

The underlying difficulty was, of course, that there were a very large number of Category 2 patients in the ED on the evening in question. On the 17th December 2022 presenting to triage between 00:00 hours to 23:59 hrs were;

2 Category 1 patients

94 Category 2 patients

127 Category 3 patients

14 Categories 4 & 5 patients.

42% of all presentations were Category 2.

[Nurse C], when [they] telephoned [Senior Staff Member A] on the evening of the 17th December 2022 at approximately 21.45 sought assistance with the situation in the ED, and when [Senior Staff Member A] arrived in the ED reported 67 Category 2 patients in the ED with waiting times greater than 10 hours.

The Escalation Report that [Nurse C], sent to UHL Managers at 6.19am on the 18th December 2022 recorded that there were 72 patients in Zone A at 1.00am, 45 in Zones B&C and 29 in Paeds, 12 in Resus and 7 in triage. This Escalation Report is annexed to this Report at **Appendix 11.**

Given that under the Manchester Triage System the ideal maximum time to first contract with a treating clinician for a patient categorised as Category 2, as Aoife was, is 10 minutes, it was clearly impossible for that timeframe, or anything remotely like it, to be met having regard to the fact that there were of the order of 168 patients in the Emergency Department which has capacity to cater for 49 patients at any one time and, for most of the period in question, either only an SHO or, for part of the time, a Registrar (when the second Registrar was not required to assist in Resus) available to see those patients.

There are, of course, overriding general issues which need to be addressed in the context of such a situation arsing in the first place. It clearly creates an impossible situation where patients, who are meant to be seen within a very short period of time (precisely because they have been assessed as needing to be seen within that time frame), cannot possibly be seen with anything remotely like the urgency required because of the complete imbalance between numbers of Category 2 patients awaiting being seen by a doctor and the number of doctors available.

It is hard to disagree with [Dr F]'s assessment that such a situation demonstrates that the system is broken. However, as commented on a number of occasions in this Report, the fact that the system may not be capable of working in a way which is even close to ideal does not mean that attempts do not have to be made to do the best that can be done with the resources available and in the circumstances prevailing.

In the absence of any better system being in place, all that was available on the occasion in question was the possibility that a nurse might be able to identify patients who were considered to be in particular need of being seen urgently by a doctor and seek to suggest to doctors that the patient concerned might be advanced "up the list".

However, even that system appears to have been quite haphazard. The experience of [Nurse B] in attempting to have Aoife seen more quickly demonstrates the inadequacy of such an ad hoc system.

[Nurse B]'s evidence was that at 23.50 on the 17th December 2022 Aoife was feeling nauseated and vomiting. [Nurse B] requested a doctor that [they] might give Aoife something to help with those symptoms and Aoife was prescribed anti-emetics and IV fluids. [Nurse B]'s evidence was that [they] did not ask the doctor to see Aoife at this time. [They] assessed Aoife again at 1.40am. Aoife's blood pressure was low, her heart rate slightly elevated and she still had a temperature. [Nurse B] says that there was no doctor in Zone A at this time so that [they] went into Resus and spoke to [Dr B] explaining Aoife's symptoms which included aches and pains in both legs. The doctor prescribed IV Keral and advised the nurse to elevate Aoife's legs which [they] did. [Nurse B] at interview told this Investigation that [Dr B] told [them] that [they] could not see Aoife due to the acuity in Resus (page 13 Investigation Interview). [Dr B] does not recall being asked to see Aoife (page 14 Investigation Interview).

At approximately 2.30am [Nurse B] took blood cultures from Aoife. At 4am [Nurse B] again assessed Aoife. Her basic vital signs had not improved and [Nurse B]'s account to this Investigation was that [they] went to

[Dr C] in Resus, [their] evidence being that there was no doctor in Zone A at the time. [They] expressed [their] concerns about Aoife's blood pressure and temperature. [Nurse B]'s evidence (page 15 and 16 Investigation Interview) was that [Dr C]:

stated that it sounded viral and to continue paracetamol every four hours. I suppose at this point I wasn't quite happy with the comment that there was, how many, 80 patients plus in Zone A at this time. I suppose for one person I couldn't manage Aoife as much as I could inside Zone A at that point. I kind of requested could she be put into Resus to have more of a management, someone looking at her more than I could as I kind of went into her I suppose an hour and a half, every two hours as those were the times I could get into Aoife. I suppose at that point [they] said that she had interventions, she didn't need to come in. I suppose I wasn't kind of happy with that either so I requested an antibiotic to see if it could just somehow treat the temperature because the temperature didn't come down. I basically didn't get what I asked for.

[Dr C]'s evidence was that Aoife's case was not escalated to [them] (page 6 Investigation Interview).

..I just need to make a point that I didn't have any clue about Aoife Johnston's case. Like it wasn't escalated to me as I was in charge of Resuscitation room and I didn't get a chance to get out of Resuscitation room until 8 in the morning, until the next handover in the morning time.

When the conflict in evidence was put to [them] for any final comment [they] might have, [Dr C], by email dated the 1st July 2024, commented that in [their] view any verbal order to give medications or continue an existing plan of management would not be valid or medically appropriate if the nurse had not received the ordering physician's signature on same and [they do] not recall any approach by any staff member in respect of Aoife's case. [Dr C] also commented that:

"In such situations, the proper channel of communication in escalations of deteriorating cases is as the following:

a- The zone's nurse to the doctor assigned to the same zone/ patient. Or,

b- The zone's nurse to the ED REG. Or,

c- The zone's nurse to the CNM to escalate.

In this case no evidence was provided to me that any of these pathways of situation escalation was followed."

[Dr C] also commented that whatever Aoife had received before being seen by a doctor in the early hours of the 18th December 2022 could not be classed as an intervention and [they are] clear that [they] did not at any stage give advice or instructions to [Nurse B] that as Aoife had received interventions she did not need to be brought to Resus.

[Nurse B] spoke to [Dr D] about Aoife at 5.45am on the 18th December 2022. [Dr D] was in Zone A at the time and [they] agreed to see Aoife.

At interview [Nurse B] gave an account of escalating Aoife's case to [Nurse C] at the two huddles ([Nurse C] referred to these as safety pauses) that took place over the course of [their] shift from 8pm on the 17th to 8am on the 18th December 2022. At page 18 of [their] Investigation Interview:

There is normally we would do huddles so every so often with the night duty we do a huddle and that is basically going through every patient in that area. That would be the point where we would express our concerns regarding patients who we are worried about and that night I escalated Aoife to [Nurse C] both of those times.

[Nurse C] at page 39 of [their] interview stated that [they] phoned [Senior Staff Member A] at 9.45pm on the 17th to tell [them] that the situation in the ED amounted to a major emergency and that support was needed. [They] then had to help care for patients in Resus due to the lack of nursing staff and the numbers of very ill patients. After a huddle with nursing management at 1.30am [they] went to the zones (page 44 first Investigation Interview):

I went to the zones to try and get a handle on what was going on there and just to get a feel from [Nurse B], any concerns or whatever. So during those handovers, which I tried to around 2 or 2:30, around 4, 4:30, [Nurse B] would have reported to me that Aoife was in cubicle 2 and that she had presented with pyrexia and vomiting and [Nurse B] had given her fluids and paracetomol and that [Nurse B] had spoken to the doctor around her. But there was no comprehensive handover without interruption, without,

you know, you are trying to get a handle on what is going on and [Nurse B] dealing with, I think [they] had up to 70 patients in that area. So everything you do and everything you say is not in a controlled and in a non-stress environment. So even during those safety pauses, patients were coming to the desk, patients were asking us for information, patients were looking for painkillers, and patients were looking to speak to me, the manager. So that is what [Nurse B] had reported to me on Aoife during the first, but I can tell you [they] reported very unwell patients in that area as well that [they] had spoken to doctors around that were triggering sepsis that needed to be seen.

[Nurse C] set out that there were a number of very ill patients in Zone A and the difficulty for nursing staff in the circumstances was to identify who was going to deteriorate and who should be seen first (page 45 of [their] first Investigation Interview).

The simple fact is that, until a very late stage when [Dr D] was asked to see Aoife, the ad hoc system just did not work. It seems clear that part of the reason that it did not work was precisely because it was ad hoc with little or no established process and was being implemented at a time when all concerned, both nurses and doctors, were operating under extreme pressure. The fact that none of nurses or doctors concerned appeared to be aware of Aoife's sepsis risk compounded this situation.

While the evidence does suggest that this weekend was one of the worst for overcrowding in UHL ED, nonetheless the general levels of overcrowding experienced over time suggest that not insignificant difficulties of the same type would have applied on many occasions. It follows that the ad hoc system for identifying patients who might be in need of particularly urgent attention was one which was unlikely to operate satisfactorily in times of pressure.

Unless and until the more fundamental questions concerning ED in UHL are addressed, there will always be potential problems of this type. However, the implementation of the recommendations of the Review Group in respect both of the establishment of a monitoring facility and the possibility of an objectively based re-triage system, will, in my view, go some way towards alleviating the problems identified even if not eliminating them. As set out in Chapter 8 there has been some progress in this regard since December 2022.

In addition, it does need to be said that procedures and processes which may work perfectly well in relatively "benign" conditions may inevitably come under strain when the conditions become more challenging. It is

not, however, sufficient to leave unaddressed questions surrounding how those procedures and processes are to operate in such challenging conditions not least where, as is the case in UHL, those challenging conditions occur with great frequency.

In that context it is appropriate to refer to the literature which addresses the question of staff becoming inured to difficult conditions.

Dr Mark Doyle provided this Investigation with an article written by R Amalberti (Cognitive Science Department, Bretigny sur Orge, France), C Vincent (Imperial Collage and St Mary's Hospital, London) and Y Auroy, Percy Military Hospital, Paris, France) *"Safety By Design: Violations and migrations in health care: a framework for understanding and management".*

This article (annexed to this Report at Appendix 12) refers to *"the pressures on individuals and systems to move towards the boundaries of safe operation, as workers are constantly having to adapt and react to pressures for increased performance and productivity which erode the margins of safety. Furthermore, these violations can become more frequent and more severe over time so that the whole system ''migrates'' to the boundaries of safety until an accident or recalibration occurs which forces a realignment. These external pressures, coupled with individual rewards and benefits, may over time modify the work being carried out, lead to rules and recommendations being progressively ignored, and eventually greatly increase the possibility of disaster as the organization becomes accustomed to operating at the margins of safety."*

There can be little doubt but that the conditions in UHL ED were very frequently extremely challenging for all staff concerned. It is easy, therefore, to see how what might be considered the "baseline" for a normal situation may, in such circumstances, drift upwards so that staff come to take as normal conditions which really ought not to be considered such. This is an understandable phenomenon supported by the literature. It does, however, mean that there may have been an unconscious acceptance of a level of challenge as normal, or at least, reasonably normal, when, in truth, the situation may be well beyond what might be objectively considered to fall within normal bounds.

That being said, it is clear that, by any standard, including what might have been typical in UHL, even if not normal by objective standards, the situation in the ED over the weekend of the 17thto the 19th of December 2022 was most severely challenging.

In addition it seems appropriate to comment that there may not, at the time in question, have been sufficient awareness of the importance of the use of the sepsis form. The primary purpose of that form is, of course, to record information concerning a sepsis risk patient and to indicate the steps that should be taken at various stages. However, the existence of such a form is also likely to play a role in drawing attention to all concerned of the risk of sepsis to the patient in question. As noted previously, the absence of the form in Aoife's case may well have contributed to the lack of awareness of her potential condition which may, in turn, have contributed to her not being seen by a doctor in a timely fashion.

It should be added that the Investigation has obtained the strong impression that there is much greater awareness now, tragically not least because of Aoife's case, about these issues.

However, given that lack of awareness, it does seem clear that the fact that Aoife did not go to Resus was a major contributory factor to the tragic outcome which occurred. It is important to emphasise that this is not to say that there was anything wrong with Aoife not going to Resus. Rather it is to emphasise that the fact that she did not go to Resus created an additional need to ensure that Aoife was treated in the zones in the same way as she would have been treated had she been in Resus. The lack of awareness of Aoife's potential condition undoubtedly was a significant factor in that not occurring.

6.2. Overcrowding

All of the evidence points to the fact that a significant contributory factor to the difficulties encountered in UHL ED over the weekend of 17th and 18th December 2022 was the severely overcrowded nature of the ED on that occasion. There are a range of factors which might be said to have contributed to that situation. Some of them are national and apply to all, or almost all, Emergency Departments. To the extent that overcrowding in UHL may be, on average, worse than most other level 4 hospitals, some factors have been identified in the evidence which provide, at least in part, an explanation for that fact.

It is beyond the scope of this Report to attempt to propose solutions to what has undoubtedly been an intractable national problem of overcrowding in EDs. However, it is important, for the purpose of this Investigation, to seek, at least in general, to identify factors which particularly impact on Limerick for the

purposes of considering whether there are measures which could have been adopted to minimise the extent to which the problem in Limerick might be considered to be worse than elsewhere.

At a very simple level, it can be said that an Emergency Department will be overcrowded where the number of patients presenting exceeds the ordinary capacity of the Department itself. However, within that overall situation, a number of important factors need to be recognised. First, there is the question of patients presenting to an Emergency Department in the first place. The evidence suggests that the number presenting to the Dooradoyle hospital are proportionally larger than in other comparable level 4 hospitals. The reason for that situation needs at least to be considered for the purpose of determining whether there are measures which can and should be adopted to improve that situation.

Second, it is clear that, at almost all times, there are a significant number of admitted patients who are still present on trolleys in the ED. These patients are clearly adding to the overcrowding problem and it follows that it is necessary to consider whether there are measures which could/can alleviate that situation. The underlying problem stems from the fact that, if there are more admitted patients than ordinary hospital beds to accommodate them, then necessarily some patients will not be able to be allocated an ordinary hospital bed but will have to go somewhere. Where there are wards not immediately in use (such as wards used for day care, during weekends) these may be opened as so called “surge facilities”. Otherwise patients will be on trolleys which can either be in the Emergency Department, as so called “boarders”, or as additional patients on trolleys on wards. As appears elsewhere in this Report, significant issues have arisen as to whether, both in general terms and on the occasion in question, the burden of carrying those additional patients who have been admitted but cannot be given an ordinary bed should be distributed within the hospital as a whole.

However, apart from that question, the issue arises as to whether there are measures which can and should be adopted to minimise the total number of patients requiring beds at any given time and the potential need for additional beds. At the end of the day, the ultimate solution to overcrowding must be that the number of admitted patients is no greater than the number of beds available for them. In that context, it is necessary to look at a number of points along the journey of a typical patient who is admitted through the ED. The starting point, to which the Report will shortly turn, concerns the question of whether too many patients are admitted in the first place. The second issue concerns the length of time that each admitted patient remains in hospital. There are in turn a number of factors which may influence that latter question including issues

around the speed at which appropriate diagnostics and expert consultation can take place so as to determine appropriate treatment and also the speed at which patients can be discharged involving first a decision by the appropriate consultant to the effect that the patient concerned is clinically suitable for discharge but also, importantly, issues surrounding whether it is possible to actually discharge the patient where the patient in question may need to go to a step down facility or only be discharged to home when suitable Home Support packages are in place. There can also be questions around the speed at which a patient may be considered to be clinically appropriate for discharge which may turn on whether an appropriate discharge decision can be delayed because some relatively straight forward matter (such as final tests or the availability of services such as physiotherapy) may itself be delayed.

All of these latter mattes come within the general heading of “Patient Pathway” and were the subject of detailed consideration by the PMIU during their visit in the middle of 2022. It is appreciated that the number of patients being admitted can vary from time to time for a whole range of factors and that the length of time which it may be appropriate for any given patient to remain in hospital, even if the patient pathway is optimal, can vary so that the relevant mix of patients at any time might legitimately explain some differences in the average length of time being spent in an acute hospital setting. However, a perhaps unduly simplistic set of figures may give an indication of the type of problem that these factors can generate.

If an average of 50 patients a day are admitted to the hospital through ED and if each of those patients takes, on average, 5 days before they are discharged, then it follows that such patients would require an average of 250 beds to enable all of them to have an ordinary hospital bed for the duration of their stay. If, on the other hand, 60 patients on average are admitted each day and each spends an average of 6 days in the hospital then the figure of 250 grows to 360 and the need for an additional 110 beds becomes immediately apparent.

The first part of that equation concentrates on the number of patients who were admitted through ED. The following table shows, for 2022, the number of patients presenting to ED in UHL and the national average for the same figure together with the number of patients being admitted both in UHL and nationally.

UHL Attends/Admits 2022		
2022	Average Daily Attendances	Average Daily Admissions
Model 4's (Excluding UHL)	185	45
UH Limerick	219	68

It is immediately clear that UHL has a somewhat higher number of presentations but also a significantly higher percentage of presentations resulting in admission. In the latter case it would appear that, for every 100 presentations, 27% more admissions take place in UHL over the national average.

It seems to me that this issue requires further detailed research. However, on the basis of the accounts given to me, a number of factors have been suggested as helping to explain that phenomenon.

First, it has been argued by senior clinical managers that the figures for UHL are not necessarily calculated on precisely the same basis as are those of some other hospitals. This issue comes down to whether or not persons who attend injury units outside of the main hospital are or are not included in the figures. Such facilities typically deal with those who have, in the overall scheme of things, relatively minor injuries or complaints so that very few of those attending such facilities will end up requiring to be admitted to an acute hospital. It follows that the inclusion of presentations to such facilities as part of the overall figure of presentations to the acute hospital has the effect of reducing the percentage of admissions to presentations. A similar analysis would apply to any Level 4 hospital which does not have an outside minor injury unit which would have the effect of diverting patients with lesser injuries/illnesses from the ED in the Level 4 hospital. The overall point is the need to ensure that relative figures are truly comparative.

This occurs simply because a significant increase in the number of presentations (by including those who present at such facilities) with only a small increase in the number of admissions necessarily reduces the overall percentage. It is clear that UHL does not include presentations to the units in locations outside the main Dooradoyle hospital in its figures. It is suggested that some other hospitals do include, as part of their total number of presentations, those who present to outside units under their general auspices. This can result in figures not being comparable. It would, in my view, be useful to determine just how significant this issue is and to produce figures which can confidently be shown to be comparable on a like for like basis.

Leaving that aside, a number of other factors have been put forward for suggesting an explanation for the higher number of admissions (as a percentage of presentations) in UHL. One factor that was suggested by

some as being said to apply nationally is that attendance at an ED is seen as a way of gaining access to diagnostics or expert consultation on a significantly faster basis than would apply if waiting to see a consultant or obtaining appropriate diagnostic tests on an outpatient basis. Obviously the extent to which this may explain additional attendances at Emergency Departments may require more detailed research and will, necessarily, apply to all hospitals at least potentially. However depending on the number of consultants in any acute hospital, by reference to the population which that hospital is meant to cover, then the extent to which it may be possible to obtain diagnostic or expert consultation in the ordinary way as an out-patient may be differential. Where those problems are more acute then it follows that the “word on the street” may be such as to encourage people to seek to fast track their medical assessment through ED. However, senior clinicians did not agree that this was a significant problem. It was suggested that where such patients presented, those patients were not admitted unless there was a clinical need for same. This issue might benefit from additional research.

A further factor may stem from the fact that UHL, as the level 4 hospital in the Mid-West Health Region, is not only the only level 4 hospital in that region but also operates without the presence of any level 3 hospital to take some of the burden. Historically, there were Emergency Departments in other hospitals within the Midwest Region but, in 2009, those hospitals became confined to providing injury or other clinics which offer a lower level of care in terms of the types of injuries or conditions which they can treat. It follows that some patients who might, previously, have been treated in other hospitals must now either go directly to Dooradoyle or may be referred to Dooradoyle because their particular condition is not considered appropriate for treatment other than in an acute hospital. It was suggested in evidence that the numbers referred to Dooradoyle in that latter way were quite small.

The starting point for consideration of this issue has to be to look at the historical situation when, in 2009, following the delivery of the Horwath Report in 2008 it was decided to reconfigure the provision of health services in the Midwest which reconfiguration included the closure of the EDs in Nenagh, Ennis and St. Johns Hospitals. These hospitals now operate injury clinics which deal with a limited number of minor injuries. The Emergency Department for the Mid-West region is in UHL.

Evidence was given in the course of this Investigation that the Horwath Teamwork Report in 2008 was the roadmap for the reconfiguration of services in the Midwest. That Report found that acute general hospital services were being provided across four stand-alone hospital sites (the Mid-Western Regional Hospital

Dooradoyle, the Mid-Western Regional Hospital Ennis, the Mid-Western Regional Hospital Nenagh, and St John's Hospital, Limerick). Horwath found that the service configuration was not delivering the quality standards required and needed "to change fundamentally in order to be able to deliver international best practice" (page 24) and that in essence acute emergency care in the Midwest was too fragmented.

Horwath recommended (page 32) that there should be only one regional, well resourced, general adult critical care service for the Midwest with one regional A&E 'centre of excellence' at Dooradoyle (page 35)

Horwath stated (page 58) (note the emphasis was added by the authors of Horwath):

"The Dooradoyle site currently has 472 beds (375 in-patient and 97 day case beds), with development plans for transferring obstetrics, and for additional beds through the co-location project[40]. This would significantly increase the site's bed base.
If sufficient accommodation could be provided and the current site could be reconfigured, then the ***Dooradoyle site should be designated as the regional 'centre of excellence' for the Mid-West****.*
However, consideration must be given to the economies of scale in developing the existing site to provide a modern, 'fit for purpose' facility, or whether a new purpose-built regional 'centre of excellence' should be developed. The list of reconfiguration/refurbishment (excluding any private co-location build programme), is substantial and includes:

- *New obstetrics, midwifery and neonatal unit;*
- *New elective orthopaedics unit;*
- *New or refurbished A&E;*
- *New or refurbished critical care unit;*
- *Complete ward refurbishment to infection control standards; and*
- *New additional in-patient beds, totalling 135."*

At page 71 Horwath highlighted, quite literally, the following:

"The over-riding principle is that no acute service will be withdrawn from the current general hospitals until the regional 'centre of excellence' is resourced and ready to deliver that service with reference to international quality standards."

It is clear from Horwath that, for the implementation of its reconfiguration recommendations, the hospital site at Dooradoyle required a very significant number of new inpatient beds. These beds did not materialise despite all serious injuries and illnesses being directed to the ED in UHL from 2009 with the injury clinics in

the region dealing only with minor matters. The consequent pressures this placed on the ED in UHL are clear. Doubtless the ability to bring additional beds on stream at an early stage was significantly impacted by the recession which occurred at the time of the closure of the other Emergency Departments. However, even in that context, it is worthy of note that the Horwath Report, at page 84, stated that the capital investment required for the implementation of the programme included the additional build and redevelopment of the Dooradoyle site to include a net additional 135 inpatient beds and went onto suggest that this extra capacity should be put in place in Dooradoyle BEFORE the closure of the other emergency departments in the region.

[Senior Staff Member D] gave evidence that the Horwath Teamwork Report stated that, prior to the reconfiguration of services in the region, 177 beds should be delivered on the UL Hospital site in Dooradoyle to bring bed numbers up from 472 to 649 (page 14 Investigation Interview). This did not occur. By email of the 4th June 2024 [Senior Staff Member D] clarified that [they] should have referenced 170 beds, not 177.

Evidence was given by [Senior Staff Member D] that Horwath recommended the development of a centre of excellence in UHL as it pertained to the ED with the provision of a 24/7 consultant led and delivered Emergency Department (page 14 Investigation Interview).

On reviewing the Horwarth Report between pages 57 and 60, it is clear that the precise figures for the demand for additional beds to enable Dooradoyle to operate as a Centre of Excellence depended on a number of contingencies. There was, at the time in question, a Government policy which favoured the co-location of private hospitals on the same site as public hospitals. There is reference in the Horwath Report to the fact that there was a press announcement on the 5th of July 2007 which suggested that a co-location project for Dooradoyle then under consideration would produce 138 in-patient beds.

The figure of 170 beds given by [Senior Staff Member D] was taken by subtracting the "Centre of Excellence" requirement for 642 in-patient beds from the then current number of 472 beds present at Dooradoyle. However, I am not sure that even that is a correct calculation for the Report makes clear that the then current capacity of Dooradoyle of 472 beds only included 375 in-patient beds with 97 day-case beds. Thus the shortfall in in-patient beds was in fact 267 and not 170. However, the Report also refers to a net requirement of 135 in-patient beds. This appears to be arrived at by subtracting the anticipated in-patient beds in the proposed co-location project from the total together with what was assumed to be the relocation of obstetrics and orthopaedics.

Be all that as it may, it is clear that there were a number of different assumptions or scenarios that might have given rise to different total numbers of in-patient beds being required in the main Dooradoyle Hospital. However, on any view, the number required was very significant and, importantly, was said to be required to be put in place before the EDs in the other hospitals in the Midwest Region were closed. Also, whichever scenarios ultimately turned out to implemented, the number of additional beds, even today, falls very much short of the number then indicated as being required to enable the project to be properly implemented.

[Senior Staff Member G], gave evidence to this Investigation that [they were] involved in the reconfiguration of health services in the region from 2008 (page 26 of [their] Investigation Interview):

> At that particular time I remember the team work support("Report") said that the Model 2s or the smaller hospitals were unsafe and we needed to centralise acute surgery, critical care and the emergency departments. At the time we had 472 beds in UHL. The recommendation at the time was that we would get 170 beds by 2010. That would bring us up to 642 beds. That was based on the activity which was 40,000 patients in 2008. So roll on to December 2023 and we have 535 beds in the region and over 80,000 attendances.

It may well be that there were sound clinical reasons for the measures adopted in 2009. Some of the evidence which I obtained would suggest that, at least on some occasions, the other hospitals in the Midwest Region, while operating Emergency Departments, were not, in practice, able to provide the same level of service as can be provided in Dooradoyle.

Be that as it may, however, it seems inevitable that the measures taken at that time in respect of those other hospitals were going to lead to a materially increased demand in Dooradoyle so that the measures adopted in 2009, even if appropriate, required a significant expansion in the facilities in Dooradoyle to take up what was inevitably to be the additional burden which would stem from those other hospitals not having an Emergency Department.

These additional in-patient beds were not put in place in UHL and acute services were withdrawn from the general hospitals. Ultimately this left the ED in UHL dealing with a higher demand without the recommended capacity to deal with same.

[Senior Staff Member G], at [their] Investigation Interview (page 27) referred to the first additional beds the group got:

> The first beds
> we got were in 2020 and they were so welcome, 98 beds during Covid and that was fantastic and the beds in Croom also but it is on the UHL site really the beds are needed. I think that has been the single biggest issue for us over the years around bed capacity because it is very hard for the Emergency Department to function when they have boarded patients, it is just congestion.

It does seem important to emphasise this point. The Horwath report was absolutely clear that Emergency Departments in the Midwest outside of Dooradoyle should not be closed until Dooradoyle was upgraded. That did not happen. Even to date only 98 extra beds have been provided with an additional 16 beds under construction in a modular addition to the hospital together with a further net 71 beds due during 2025 [14]. The situation today is that UHL is still well short of the number of beds recommended by Horwath as being required to allow all EDs in the Midwest to be relocated to Dooradoyle.

While it may well be that the recession in 2009 significantly delayed the construction of additional facilities in Dooradoyle this does not take away from the fact that Horwath was very strong in its emphasis that the ED facilities in other hospitals should not be closed until Dooradoyle had been extended. In addition it needs to be strongly emphasised that Horwath was based on assessments made in 2008 as to the needs of Dooradoyle. On any view, an assessment, on a similar basis, today would identify a greater need for further beds on the Dooradoyle campus. In circumstances where it will only be in the latter part of next year (some 16 years after the closure of the other facilities) that the beds indicated as being required by Horwath will be on stream, when coupled with the undoubted increase in demand which has occurred since that time, it is hardly surprising at all that Dooradoyle suffers from persistent overcrowding with all the consequences for the Emergency Department that this gives rise to.

Finally, on the question of the number of admissions to UHL ED, it was suggested by some doctors, and by the PMIU, that there may be a question concerning the relative reluctance of less experienced doctors to decide that a patient does not need to be admitted. Obviously, the question of whether a patient needs to be admitted requires clinical judgement. There will, doubtless, be many cases where someone either obviously needs to be admitted or equally obviously may only need some form of treatment which can be

[14] Chapter 7

administered with the patient being allowed to go home or to some other suitable location. However, there will inevitably be areas where the required judgement is more finely tuned and it is suggested that, in some cases, an experienced doctor may have the confidence to take the view that a particular patient does not require to be admitted in circumstances where a less experienced doctor may not have the same confidence. It has been pointed out that the converse can also be true. An experienced doctor may sometimes admit a patient whom the less experienced doctor might send home.

While it is undoubtedly highly important that patient pathway issues are addressed so as to minimise the length of time that any typical patient needs to stay in an acute hospital, it seems to me that the question of the level of admissions also needs to be addressed. This will obviously require more detailed research to enable the precise causes of the high admission rate through UHL ED to be identified and thus assist in considering measures that might be in place to attempt to bring the number of admissions per presentation back towards the national average to the extent that this may prove possible.

Evidence was heard by this Investigation of patients who "self present" at the ED, i.e. where the patient concerned has not seen a General Practitioner first and been referred on by that GP. The reasons for this are beyond the scope of this Investigation. However, such attendances do add to the numbers presenting at an ED, including the ED in UHL, which is relevant to this Investigation. In an effort to deal with this phenomenon of self-presenting attendees at the ED in UHL, [Senior Staff Member D] gave evidence (pages 32 and 33 Investigation Interview) that recently the hospital has put in place a system whereby a patient attending at reception in the ED who has not been seen by a GP will be, if appropriate, referred to the Shannondoc triage nurse and again, if deemed appropriate by the nurse, to the Shannondoc GP for treatment. This is the second time this system has been put in place:

> So if you present to the Emergency Department and you are asked by reception have you seen your GP, no, and the problem is X, you will be diverted currently to the streaming from the front door service where you will be seen by a Shannondoc triage nurse. If the Shannondoc triage nurse believes it appropriate you will be seen by the Shannondoc doctor.

[Senior Staff Member D] did make clear in [their] evidence that the number of patients that are deemed appropriate to see the Shannondoc GP on any day is a singular figure of less than 10 (page 33) and that the number of patients attending the ED unnecessarily is very small.

The experience of that initial triage system for self-presenting patients does seem to be consistent with the view that there are few patients who self-present who would be unlikely to have been referred to ED had they first seen a doctor. On that basis it may well be necessary to look elsewhere for an explanation for the high number of presentations to UHL ED. Apart from the absence of Category 3 hospitals in the Midwest Region, it also appears likely that it is necessary to take into account demographic factors such as the age profile and level of deprivation in the region as material contributors to the number of presentations. It may, therefore, be that there are factors which make it likely that there will be more presentations to an Emergency Department (whether in Dooradoyle or elsewhere) in the Midwest Region compared with other regions. If such factors provide a full explanation for any differences, then it may be that the only answer is to provide a commensurate increase in the resources available for emergency medicine in the region. However it is appropriate that research be carried out to seek to identify whether there are factors which could be dealt with which might reduce the number of presentations and admissions.

6.3. The Decongestion Issue

(a) The Operation of the Protocol

This Report already sets out in detail some of the significant and material conflicts of evidence concerning the reasons why the decongestion protocol was not operated on the night and morning of the 17th and 18th of December. As already noted, it is not part of the function of this Report to resolve those conflicts of fact. However, irrespective of the reasons why the protocol was not implemented (or at least was not implemented until well into the Sunday morning), nonetheless some important issues can be addressed. Some of these questions have been briefly addressed in the context of that part of this Report which addresses the conflicts of evidence in question.

The first such issue concerns the situation which prevailed prior to the occasion in question. It is clear that, for some time, patients had been placed on trolleys on wards as part of the way in which UHL dealt with the problem stemming from the fact that it very frequently had more patients admitted than it had beds in which to place those patients. There is no doubt but that, for some time, the INMO had concerns about the use of trolleys on wards in UHL. In addition, when the PMIU became involved with UHL in the summer of 2022, there can be little doubt but that the eradication of the practice of having trolleys on wards as a general practice formed an important part of the measures suggested by the PMIU to improve patient flow. My

attention was drawn to the slides which formed part of the presentation by the PMIU at what was described as a “Staff Engagement Event” on the 14th July 2022. Under a slide headed “AIMS”, and annexed to this Report at **Appendix 13**, four matters are identified being:-

1. Remove ward trolleys
2. Improve and protect streaming pathways;
3. Improve and protect elective pathways;
4. Reduction in Emergency Department congestion.

Those who were involved in interacting with the PMIU indicate that a strong emphasis was placed on the aim of removing ward trolleys. As I understand the evidence, it is said that the thinking behind that suggestion was that the presence, on a regular or on an almost permanent basis, of ward trolleys made the so called “patient pathways” less efficient thus leading to patients spending more time in hospital than necessary thus in turn contributing to overcrowding.

In the context of that presentation, it should also be noted that one of the four aims involved “Reduction in Emergency Department Congestion”.

In interview with officials from the PMIU, it was agreed that the elimination of ward trolleys was a significant element of the measures suggested to seek to improve patient flow. On the evidence there clearly seems to have been a disagreement between the PMIU and Senior Managers in UHL on the question of the role of ward trolleys. [Senior Staff Member D], gave evidence at interview (page 42) that the risk rating of a patient admitted on a trolley on a ward was an Amber 9. The risk rating of a patient admitted on a trolley in the ED was 25 out of 25, the highest level it can be (page 42 of [Senior Staff Member D]’s Investigation Interview). However, that debate seems to have applied to the question of whether placing patients on ward trolleys should form part of the general practice of the hospital in circumstances where the number of admitted patients exceeded the number of beds available. In the view of UHL Senior Clinical Managers, it was safer for those patients to be on ward trolleys rather than being in ED.

The Senior Managers in UHL accept that it was agreed to go along with the suggestions of the PMIU and it is undoubtedly the case that the number of ward trolleys reduced significantly in the period when the PMIU were present. My attention was drawn to a subsequent presentation on the 28th July 2022 which includes a graph showing the number of ward trolleys declining from a typical figure in the high teens in the latter part of June 2022 to a point where, approximately one month later, there would appear to have been no ward

trolleys. It is, of course, the case that it may have been easier to achieve a zero ward trolley position during that summer time when the overall demands on the hospital in terms of admitted patients may have been less than occurs in winter.

There is an analysis of the trolley numbers in Chapter 5.1 (d) of this Report.

The situation of there being no ward trolleys continued until the 24th October 2022. At that stage the evidence is that the Senior Managers involved, including [Senior Staff Member C], [Senior Staff Member D] and [Senior Staff Member E] agreed that the situation was such that ward trolleys would need to be used again. In passing it should be noted that [Senior Staff Member E] was on ▇▇▇ leave at the time when the PMIU were present (with [Senior Staff Member G], in accordance with statute taking over during [their] absence) but had returned to work at the time of that October decision.

It was that decision to allow ward trolleys again which gave rise to the letter from the INMO to which reference is made elsewhere[15]. Thereafter, between late October and Mid-December 2022, ward trolleys were utilised on quite a number of occasions. From the 24th October to 31st December 2022 inclusive there were ward trolleys in use at 8 am on 32 occasions. The numbers vary from 2 on the 3rd November 2022 to 29 on the 30th December 2022.

A number of observations should be made at this stage. First, the protocol in respect of ward trolleys being utilised when a certain number of admitted patients on trolleys in the ED was reached, appears to have remained in force at all material times. It is true that, during the period from late July to late October 2022, there were days when the total number of admitted patients on trolleys did not exceed the threshold which would have required trolleys with admitted patients being put on the wards. There were however days when the protocol should have been operated but was not. For example on the 11th and 12th of October there were 35 and 36 trolleys in use in the ED with nil ward trolleys in use.

As pointed out in Chapter 5, Senior Managers were clear in saying that there was no confusion about the situation namely that the PMIU had mandated no trolleys on wards ([Senior Staff Member D] page 42 Investigation Interview) and that was reversed by [Senior Staff Member E] on [their] return from ▇▇▇

[15] Chapter 5, The Role of the PMIU

([Senior Staff Member D] page 43) and confirmed by [Senior Staff Member E] in [their] Investigation Interview at page 56:

As soon as I saw the activity rise in ED, some
days there was 30 on trolleys from the date in October.
I issued the directive. The INMO objected strongly,
you have seen that letter.

[Senior Staff Member D] was clear at [their] Investigation Interview (page 41) that the data available to [them] did not support the perception that there was confusion around patients on trolleys being moved to wards:

So this perception that there was
confusion, that there was conflict, that there was a
culture of not accepting trolleys, the data does not
bear that out. If you look at Monday morning at 8 p.m.
the number of patients admitted on trolleys on the
corridor, it was very similar to the picture at 8
o'clock on Friday evening. The difference was there
were patients on ward trolleys. So the area of
congestion wasn't singularly focussed on the Emergency
Department.

At page 46 of [their] Investigation Interview [Senior Staff Member D] stated:

But I can clearly articulate that
when [Senior Staff Member E] returned, that decision was
reversed.
Ward trolleys became a safety feature in the hospital.

However, is not at all as clear that the situation was obvious to those nurses who were charged with implementing the protocol on the ground, including [Senior Staff Member A] and [Senior Staff Member K]. On the evidence, those nurses were aware in general terms of the suggestions of the PMIU. Those nurses would also have been aware of the fact that there were no ward trolleys between July 2022 and late October the same year. They would, of course, have also been aware that ward trolleys had begun to be utilised again at the end of October. However, it was not clear as to what precisely was communicated to those nurses as to the situation[16].

[16] Ibid

With this in mind this Investigation wrote to Senior Managers in this regard seeking clarification as to what was formally communicated to Non-Executive Management nursing staff following the intervention of the PMIU in the hospital in the summer of 2022 and this is also addressed in Chapter 5 of this Report.

A further issues arises as to whether, as the PMIU have suggested in evidence, their advice did not involve a total prohibition on ward trolleys but rather involved adopting measures to improve patient pathways such that the need for ward trolleys might be reduced with the use of ward trolleys remaining a possibility where overcrowding in ED justified this. In that context the PMIU point out that they received detailed figures in respect of trolleys and were, therefore, aware of the use of ward trolleys in the period after late October 2022. The PMIU had a series of follow-up meetings with relevant management in UHL and gave evidence to the effect that, during those follow-up meetings, they did not raise the question of ward trolleys being used again after October. On this basis, the PMIU suggest that it was clear that they were not opposed to ward trolleys in circumstances where this was necessary to alleviate significant overcrowding in ED but rather were opposed to ward trolleys being used for general purposes. Be that as it may, it seems clear on the evidence that Senior Nurses on the ground remained of the view that the PMIU were opposed to the use of ward trolleys and also placed some weight on the fact that the INMO were likewise opposed to the practice.

[Senior Staff Member A] on the night of the 17th December 2022, told this Investigation (page 6 Investigation Interview):

I suppose with the PMIU coming in July, that also affected decisions being made, I suppose looking at whether trolleys went to ward areas or not. September there was zero, October there was zero. You know, there were some elements of trolleys going up in November and I suppose 23 out of 31 days trolleys went up to ward areas in December. So it wasn't consistent, it was depending -- it was dependent on the Exec on call really.

In any event, by December 2022, it is clear that ward trolleys were in use on a regular basis. On being questioned in respect of the relevant protocol in that regard, each of the Senior Managers interviewed indicated that it was there view that the Assistant Director of Nursing on shift on any relevant occasion was the person who had responsibility for implementing the decongestion plan. [Senior Staff Member E] stated at page 11 of [their] Investigation Interview (emphasis added):

Q. ..In any event, we know that there was a conversation between [Senior Staff Member A] and [Senior Staff Member B]. It centered around sort of a decongestion measure to firstly open a surge facility and also to move patients to wards. Am I right in understanding, it seems to be the view of the other senior managers I have spoken to, that the actual role of that decongestion is one which is the responsibility of the Assistant Director of nursing?

A. Correct.

[Senior Staff Member C], gave evidence (page 24 Investigation Interview):

Q: Ms BURNS: I suppose my question was quite similar to Mark's and it is around the escalation. I was just wondering can the Assistant Director of Nursing, you know, implement the escalation plan without calling the Exec or is it always, does that step always have to be done?

A. I think there is no element of the escalation plan to say that the Assistant Director could not have put the trolleys up. There is a piece where that communication at the time with [Senior Staff Member B], trolleys should go up or trolleys are going up, that is just a conversation but there is no reason why -- anyone could have instigated putting the trolleys up.

By email dated the 28th May 2024, [Senior Staff Member A] confirmed that *"The OADON does have the authority to place trolleys at wards level, however, as previously stated, the placement of trolleys at ward level was discouraged by the PMIU so as the OADON discussion with the Exec on call prior to opening Surge and placing patients on trolleys at ward level was required."*

[Senior Staff Member A] also pointed out *"Of note when I advised* [Senior Staff Member C] *that I planned on opening Surge and placing one round of trolley's at ward level, with regards to the trolley's [they] did ask "what was the release valve for tomorrow" (Sunday) if this occurred but to follow up with a discussion with* [Senior Staff Member B]."

It also seems that Senior Managers were of the view that the protocol should be operated more or less automatically with it not being a situation where decisions were to be made about whether to decongest but

rather that decongestion was to be operated as soon as the relevant thresholds were hit (with the possible exception of circumstances where it was clear that beds were due to become available in early course to solve the problem in ED and bring the numbers of admitted patients in ED below the threshold for the operation of the protocol).

Thus the evidence strongly suggests that, at least by the middle of December 2022, there was no basis on which decongestion should not have been operated when the number of patients in ED exceeded 23. It is also agreed by all concerned that the first port of call in decongestion should be the opening of any available surge facility. It is also clear that this was done, although, as noted elsewhere there is a question around why only 7 beds (as opposed to the physical capacity of 10) in the ward concerned were utilised.

Given the more or less automatic requirement, having regard to the numbers involved, to move trolleys to wards, on the evening of the 17th December and given the potential that this would have had for markedly improving the overcrowding situation, the conflict of evidence as to why ward trolleys were not utilised becomes all the more relevant. It should be said that it does not appear to be the type of conflict of evidence which can be attributed to understandable, but genuine, differences of recollection.

(b) Should further or follow up measures been adopted?

It is next necessary to move onto the question whether there were further measures going beyond the implementation of the protocol, which should have been adopted to attempt to address the overcrowding problem. In that context, it is important to refer to the escalation report of [Nurse C] annexed to this Report at **Appendix 11**. However, before turning to that, it should be borne in mind that, on [their] evidence, [they] had been told that the ward trolley element of decongestion was not going to be used on the night of the 17th of December and early morning of the 18th of December so that [their] views in seeking further escalation need to be seen in that context.

In addition it is necessary to consider whether [Senior Staff Member B] should have followed up on the decongestion issue. [Senior Staff Member B]'s evidence was that [they were] contacted by [Senior Staff Member A], at 10.33pm on the evening of the 17th December 2022 and notified of the situation in the ED. [Their] evidence was that [they] and [Senior Staff Member A] discussed options with [Senior Staff Member B] advising the opening of the surgical day ward as a surge facility, sending four hip fracture patients to 8B and four more to 3D, to use six vacant beds on the system and a surge with trolleys to go to each of the

wards available to take trolleys (page 10 of [Senior Staff Member B]'s Investigation Interview). [Senior Staff Member B] was clear that [their] role was an out of hours role to give advice to and support [Senior Staff Member A] and that [they were] not a member of the Executive Management Team ("EMT").

[Senior Staff Member A]'s evidence was that [they] requested that trolleys go to wards and that it was for the [Nurse E] to action that but it was not done (page 14 of [their] interview with this Investigation).

At interview [Senior Staff Member E] at page 17 stated (emphasis added):

<u>So [Senior Staff Member B] gave an instruction I believe, as stated by [them], that the trolleys should be moved to ward level and that did not happen. [Senior Staff Member B] should have checked and challenge that and monitored it because that would be normal to follow up</u> on instruction. And if the crowding continued, which it did, the Executive Management Team were to be contacted. So the COO, the Chief Clinical Director and the Chief Director of Nursing would be contacted either individually by the staff or by the Exec-on-Call. Then there would be a number of measures taken, it would become very decisive and very directive.

In accordance with fair procedures and the procedural methodology of this Investigation, [Senior Staff Member E]'s evidence was put to [Senior Staff Member B] for [them] to respond if [they] wished.

By email dated the 21st May 2024 [Senior Staff Member B] on the 17th December 2022 responded. [Their] response to [Senior Staff Member E]'s evidence was that (emphasis added):

<u>"It is unclear on what basis [Senior Staff Member E] makes this statement or forms this view as this was not the role of the exec on call either in practice or as defined in the SOP. [Senior Staff Member E] approved the operative EXECUTIVE ON CALL SOP, and [they] must be aware that issues [they are] now criticising [Senior Staff Member B] for were not addressed in it.</u> Respectfully, [Senior Staff Member E] proposes an unrealistic and unworkable expectation of an on-call, off- site staff member that requires that staff member to be engaged around the clock supervising and monitoring experienced managerial medical and nursing staff on site. The exec on call usually worked 7 days and nights, performing their other regular duties Monday to Friday during working hours (I accept I was ███ on Friday 16th during the day<u>). We (the GMs that performed the EoC duties) were repeatedly advised in meetings with our line manager (the COO) that it was the role of the OPADON to contact us, and not for us to be checking in on them, due in part to the fact that we were working or on-call on a continuous basis."</u>

As regards contacting the Executive Management Team, [Senior Staff Member B] reiterated [their] evidence at interview that [they] understood that [Senior Staff Member C], a member of the Executive Management Team, was aware of the situation on the 17th December 2022 and that [they] had in fact texted [Dr H] in respect of the situation and received no response from [them]. [Senior Staff Member B]'s evidence was that ultimately [their] advice was not followed and that [they] at all times acted in accordance with the Standard Operating Procedure ("SOP") that was in place for [their] role at the time.

The SOP for the role of Executive on-Call that was in place at the time is annexed to this Report at Appendix 14 and was approved by [Senior Staff Member E] with the approval date stated as September 2017 and a revision date of September 2019. The document states that (emphasis added) *"In the event of an emergency situation or unusual event, the Operational ADON on duty may require advice and support from the Exec on Call via phone".*

The SOP has since been updated and is annexed to this Report at Appendix 15. This document is dated March 2024 and the "Senior Manager On-Call" is defined at the Senior Manager rostered out of normal work hours who *"can be contacted in order to provide a professional appropriate escalatory advice and support to site rostered management if necessary."* The Senior Manager On-Call is responsible for *"Being a point of escalation for any operational issues that the hospital site management out of hours has not been able to resolve, and for the escalation of operational incidents to EMT",* for *"Escalation of any major incident which either has a significant impact on the organisational perspective, significant risk to patient safety or significant communication, financial or IT implications"* and for *"Directly managing the organisation's response to an incident until EMT available".*

[Senior Staff Member B] was also on duty on the 18th of December 2022. The overcrowding and difficulties in the ED were persisting. [Senior Staff Member B] gave evidence that (email 21/5/2022):

"Additionally, on Sunday night, when I informed [Senior Staff Member G], circa midnight, that there was a request from [Senior Staff Member A] to call a "major emergency", [they] instructed me to contact [Senior Staff Member D] myself "to see what [they] thought". On that Sunday night I rang both [Senior Staff Member D] and [Senior Staff Member C] and neither answered their phones. When I reverted to [Senior Staff Member G] to advise of this, [they] had no further guidance to offer."

[Senior Staff Member E] was given an opportunity to respond to [Senior Staff Member B]'s email of the 21st of May 2024. [They] did so by email dated the 31st May 2024 stating: *"I was not criticising [Senior Staff Member B] and my statement is factual and correct as per transcript. [Senior Staff Member B] has advised [they] instructed ward trolleys to be placed. As Senior Managers, Executives/Senior Managers on call and indeed the Executive Management team would routinely follow up and check on matters when they are aware the UHL site is under significant crowding/capacity/resource pressures, this is a continuous cycle carried out by Senior Managers. [Senior Staff Member B] when questioned at the Coroners Court 'Should [they] have followed up and monitored' [they] advised in hindsight [they] should have, this was reported widely at the time.*

[Senior Staff Member B] is correct that the site manager Operational ADON is the person in charge who always has the liberty to seek advice from an experienced Executive on Call. [Senior Staff Member B] advised [they] gave an instruction.

I have no further comment as I was not on duty and therefore, as stated, I cannot understand why said instruction was not followed or why the Executive Management team was not called if there was some impediment to the implementation of the instruction."

[Senior Staff Member G], was also given an opportunity to respond to [Senior Staff Member B]'s email of the 21st May 2024. [Senior Staff Member G], in an email dated the 24th May 2024, stated: *"I have no recollection of taking a call from [Senior Staff Member B] of the night of the 18th December 2022. However, [Senior Staff Member B] may have called me but I just don't have a recollection of it".*

As a result of further observations being sought by the Investigation in respect of the question as to whether [Senior Staff Member B] should have enquired as to whether the agreed measures had been adopted, the [Senior Staff Member E] referred to a Trigger Process Flow Plan. It would appear that this document (which is marked 'Draft'), does suggest that the Executive-on-Call should be informed when measures of what are described as level 3 have been adopted. It would appear that the suggestion is that the fact that no such information was given to [Senior Staff Member B] might have drawn to [their] attention the fact that the decongestion measure involving sending trolleys to wards, had not, in fact, been put in place. On the other hand, all of the evidence points to the fact that, as a result of the discussion between [Senior Staff Member A] and [Senior Staff Member B], referred to on a number of occasions in this report, [Senior Staff Member B] was already aware of the fact that a decision had been taken to send trolleys to wards. In those

circumstances, it does not appear to me that the Trigger Process Flow Plan is of any materiality to the issues which occurred on the evening.

(c) Wider Decongestion

Some of the nurses present on the ground on the occasion in question when interviewed did raise the question of whether a major internal incident should have been declared over the weekend of the 17th/18th December 2022. In order to consider this question it is necessary to identify a number of general of issues which inform that question. First it is important to distinguish between two types of situations.

A "major internal incident" arises within the hospital. [Senior Staff Member D] gave evidence of such an event occurring (page 47 Investigation Interview):

> …when resources available are unable to cope with the workload.)

[Senior Staff Member D] explained that (page 48 Investigation Interview):

> A major emergency is a completely separate thing, that relates to the number of live casualties who are going to present to your emergency department and your ability to cater for them. That is a major emergency and you have a major emergency plan.

Obviously the question of a major emergency does not arise but the possibility of a major internal incident being being declared does need to be addressed.

[Senior Staff Member D's] evidence (pages 47 and 48 Investigation Interview) was that (emphasis added):

> On the night in question did it meet the criteria for a major incident? No, it didn't because there was ample decompression measures available. Had the ED been decompressed there would have been 40 less patients bed booked in the ED and that would have given the ability for both the nursing staff and the medical staff to concentrate on the patients who needed emergency care rather than particularly the nursing staff being diverted, looking after patients that required inpatient care.

[Senior Staff Member D] referred to a major internal incident being declared on 2nd January at page 48:

> As you are well aware on the 2nd January a major internal incident was declared and that is because we found ourselves in a similar position in the Emergency Department but all of our surge capacity had been utilised. So we had maximised our ward trolleys, we had maximised our surgical day ward capacity.

In addition, it is important to, have regard to the fact that, when action was actually taken later the morning of Sunday 18th, a number of additional measures (beyond the actual implementation of the decongestion protocol and the sending of admitted patients on trolleys to wards) were implemented. These measures involved accelerating the moving of patients to other hospitals within the UHL group which in turn involved the cancellation of some procedures in those hospitals so as to facilitate the accommodation of patients who might be moved to those hospitals from Dooradoyle. For ease of reference, the Report will refer to such measures as *"enhanced decongestion measures"* being measures which go beyond the protocol for moving trolleys to wards but which are short of declaring a major internal incident.

As earlier noted, an additional matter which needs to be taken into account in this context is the fact that, save for the opening of a surge facility, none of the first layer of decongestion measures actually took place over night into the morning of December 18th. It follows, therefore, that the situation which pertained during the latter period of the night shift and the handover to the day shift was significantly more severe than would have been the case had the protocol for ward trolleys been implemented.

As regards contacting the Executive Management Team, [Senior Staff Member B] reiterated [their] evidence at interview that [they] understood that [Senior Staff Member C], a member of the Executive Management Team, was aware of the situation on the 17th December 2022 and that [they] had in fact texted [Dr H] in respect of the situation and received no response from [them]. [Their] evidence was that ultimately [their] advice was not followed and that [they] at all times acted in accordance with the SOP that was in place for [their] role at the time.

6.4. The Dispensing of Medication in the Emergency Department

Aoife Johnston was finally examined by [Dr D] at approximately 6am on the 18th December 2022. [Dr D] queried *"viral septicaemia/septic shock,?CNS sepsis/strep pharyngitis"*, order other investigations and prescribed medication including antibiotics and a steroid for Aoife.

The prescribed medication was not administered to Aoife until over an hour later between 7.15 and 7.20am on the 18th December 2022. As referenced earlier in this Report, the protocol in respect of sepsis treatment suggests that a patient diagnosed with possible sepsis should receive a bundle of treatment within one hour. Aoife, while a query sepsis case so identified by the out of hours GP and [Nurse A], had been waiting many hours to see a doctor in Zone A. When she was seen by [Dr D] [they] too [were] concerned that Aoife had sepsis and prescribed the necessary medications to treat that condition. Given how ill Aoife was by 6am on the morning of the 18th, it is unclear if the dispensing of the medicines immediately on prescription would have prevented the tragedy that unfolded. However, the further delay in dispensing those medications at 6am is unsatisfactory and required further investigation.

[Dr D] at the Inquest into Aoife's death gave evidence (pages 24 and 25 transcript Day 2 of the Inquest) that [they] prescribed medication including antibiotics for Aoife and requested that a nurse dispense the medication. [They] stated (emphasis added):

> I did, I gave them the file (inaudible due to cough) urgency but <u>it is common it doesn't happen immediately as it should because nurses are obviously overwhelmed, like I said. So, I impressed upon them it needs to be given urgently but obviously after the fact I saw it wasn't given as urgently as I'd hoped.</u>

When questioned as to how the system for dispensing medication works [Dr D's] evidence was:

> How it works is you would find a nurse and there is many nurses working in the zone, I think there was three at the time. Many of them might be busy, they might be allocated to a patient but patients still in the Emergency Department that are not admitted, are not necessarily allocated to a specific nurse. So, you would find any nurse who may seem available, give them the chart and impress upon them how urgent it is to be given. But other than that there is no -- there is no other way of getting it done as soon as possible, other than giving it yourself which often can happen but I don't have access to the Omnicell which is where the medications are kept. Some doctors do give medication on their own sometimes when things get busy which wouldn't be how things are supposed to happen but given the state of the department it happened sometimes. Although other than asking a nurse as well as you can to give it as soon as possible, there is no better way.

This Investigation put [Dr D's] evidence to [Nurse C] for [their] view. In an email response dated the 3rd June 2024 [Nurse C] stated:

While common practice would have been as described in [Dr D's]evidence [at the Inquest] - that a doctor would see a patient and then get the nurse to administer antibiotics - the sole responsibility for administering medication does not lie with the nursing staff.

Doctors are free to administer medications themselves to any patient and certainly if they felt a patient was in need of urgent treatment. I have witnessed the administration of medication by doctors on many occasions in the past. So therefore, it is incorrect to suggest that the responsibility for procuring the prescribed drugs lies with the nurse solely.

Separately, I read in [Dr D's] evidence that [they] had no access to the Omnicell, and I would like it noted that this was a surprise to me as I certainly have had experience of some doctors having that access. I would have thought, therefore, that [Dr D] had access too. All doctors employed in the Emergency Department should have had access to it.

[Nurse C's] view was put to [Dr D] for comment and in an email dated the 5th June 2024 [Dr D] confirmed that [they] had sought to be set up on the Omnicell system when [they] started in the hospital and sent on the relevant information but that the set up did not occur. [Dr D] reiterated that (emphasis added):

"I do not recall any official guidance/protocol given with regards to the administration of medications in the ED. In my informal induction, it was explained that medications are given by nurses after you have prescribed them, and this is what I observed also to be the status quo.

<u>Common practice in UHL ED is that the administration of medications is done by the nursing staff</u>....... On the night in question, being the sole doctor tending to a large area and an unthinkable number of sick patients- I simply did not have the time to both prescribe and administer medications myself. <u>The department was so used to operating overcapacity and more time spent by nursing staff tending to stable lodgers in ED awaiting beds- prioritising these scheduled medications over those of ED patients, that it had become norm to make an ED patient wait for</u>

their stat prescribed medications. This was not the first time it had happened; it was merely the first time that there was a significant poor outcome because of it."

This Investigation sought the view of the experts assisting, Dr Doyle and Ms Burns, on this issue. Both agreed with [Dr D] that, within Emergency Departments, doctors tend to prescribe and nurses administer medications, other than for certain drugs such as intravenous morphine. Ms Burns did point out in relation to sepsis if the antibiotics had been prescribed post triage then the nurse could have administered them. Dr Doyle noted that in a well-functioning situation there would be communication between healthcare professionals so if the nurse for whatever reason could not administer the medication in a timely fashion, there would be a conversation with the prescriber and one or other would then administer the medication.

When the issue of protocols governing the collection and administering of prescribed medication was raised by this Investigation with the hospital, [Senior Staff Member E]'s office responded by email dated the 14th June 2024 that

"UHL had the following protocols in place in 2022 for collecting and administering of prescribed administrations, all attached

- *Triage Pain Medication Policy (December 2022)*
    - *Protocol for the administration of Ibuprofen for adults at Triage by nursing staff in the Emergency Department University Hospital Limerick*
    - *Protocol for the administration of Paracetamol for adults at Triage by nursing staff in the Emergency Department University Hospital Limerick*
    - *Protocol for the administration of Penthrox® (Methoxyflurane) for adults at Triage by nursing staff in the Emergency Department University Hospital Limerick*
- *Multidisciplinary Medication Policy UHL, UMH & Croom Hospital 2018*
- *ULHG Policy on Medication Management at Ward level (Ordering, Receipt, Storage and Disposal) 2023, new updated policy*
- *NMBI Medication Administration Policy (2020)"*

The Investigation was also sent a policy which is currently under draft on *"Prescribing Medications for Symptom Management at the Request of Colleagues in the Emergency Department UHL"*, which is awaiting sign off by our Drugs and therapeutic Committee. This draft policy is concerned with the administration of drugs to patients in the ED for the relief of symptoms of pain, nausea and dehydration. It is not concerned

with the treatment of conditions such as sepsis, where the administration of antibiotics in a timely fashion is vital to the prospects of a successful outcome for the patient.

The system for administering prescribed medications, once a doctor has seen a patient in the Emergency Department, is ad hoc. Nurses are not assigned to specific unadmitted patients in the ED. The system, such as it is, essentially involves a doctor speaking to a nurse when they have seen an unadmitted patient and asking that nurse to administer the prescription.

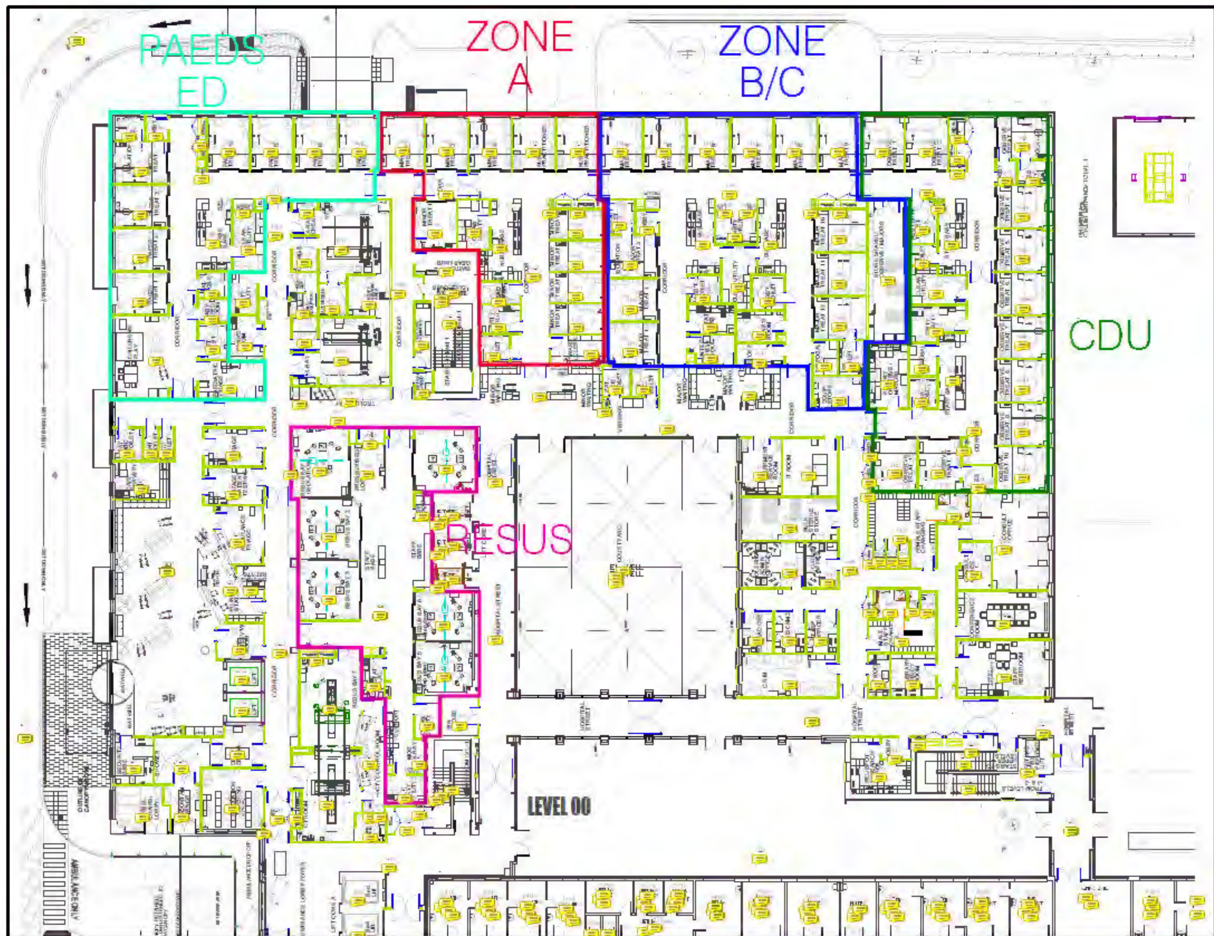
The chances of delay, such as occurred in this case, in the administration of an urgently needed prescribed medication when clinicians and nurses are working under considerable pressure are self-evident. It is recommended that a full review of the system in the ED in UHL for the administration of all prescribed medications (not simply medications prescribed for symptomatic relief) should take place in order to obviate the risks of delay once medication is prescribed.

CHAPTER 7 - SOME BROADER ISSUES

As background it is appropriate to describe the Emergency Department at UHL and its staffing.

7.1. The Emergency Department and its Staffing

The physical layout of the Emergency Department can be seen from the following plan.



Patients who arrive other than by ambulance come into a waiting area which has a number of desks at which the patient can be registered. The patient then remains in that area until their turn for triage arises. At that stage the patient is brought to one of the triage areas where the patient concerned is seen and an appropriate triage category allocated.

It will be seen from the above plan that there is a separate area for paediatric patients which, in this context, means any patient under the age of sixteen. It is my understanding that this age limit is the one generally in use for such purposes throughout the Health Service.

Adult patients will, depending on their triage result, be then sent to one or other of the areas within the ED. The Resus, or Resuscitation, area has seven bays (although it would appear that it frequently has more than seven patients assigned to it at any given time, and, on the evening with which this Report is concerned had more than double that number). If not admitted to the Resus area, typically patients who can walk (who are considered “ambulatory” in the terminology used) go to Zone A whereas other patients may be sent to Zones B and C. It also needs to be noted that those three Zones also have within them so called “boarders” being admitted patients for whom a bed in the hospital is not as yet available. Clearly the presence of such patients on trolleys adds to the number of patients in the zones and thus can contribute significantly to overcrowding in those Zones.

As will be seen from the plan, and on the evidence, the total number of ordinary positions within the three Zones is 49.

Dr Doyle drew attention to the fact that the Resus area appeared to be used for purposes other than resuscitation and the treatment of critically ill patients. It would seem that the Resus area was, in fact, used for procedural sedation and also as a monitoring area. It may well be that this factor contributed to the overcrowding of the Resus area. It is noted elsewhere that progress has been made in relation to the provision of a monitoring area, with suitable staff, which may partly address this question. Obviously, the ability to properly manage patients who require to be in the Resus area is dependent on that area not being itself significantly overcrowded. It is, therefore, important that only those patients whose clinical condition requires that they be in Resus, are actually located there at any given time. It is appreciated that the frequent overcrowding of the Emergency Department can make dealing with this issue particularly difficult and it is recommended that further consideration be given to ascertain whether there are additional measures which could be adopted to ensure that Resus is, to the greatest extent possible, used only for patients whose clinical requirements necessitate their being in such an area.

(a) Staffing

On the weekend of the 17th and 18th December 2022 during the night shift the designated nurse staffing i.e. funded posts amounted to 19 nurses plus one CNM2 in charge. The table below[17] sets out the nursing staff allocation for the ED on the Saturday and Sunday 17th and 18th December 2022, the funded posts and the numbers of patients in the ED and is helpful in setting out the situation on the floor of the Department on the evening that Aoife attended.

ED Areas	Staff Nurse Allocations Sat/ Sun	Designated Nurse Staffing i.e. funded posts Sat/ Sun night	Patient numbers in ED	Notes
Triage	1 CNM	2	17 pending	
Resus	3 SN	4	14	
Paeds	1	2	30	1 additional SN allocated.
Zone A	3 SN	4	67	2 allocated to mind the 20 boarders. Zone A is assigned 'ambulatory' patients
Zone B	2.5	2.5	Approx. 20	Patients in C & D areas have higher nursing care needs and therefore need higher nurse: patient ratios. 11 boarders
Zone C	2.5	2.5	Approx. 20	10 boarders
Clinical decision unit (CDU)	1	2	10	
Totals	14 + 1 CNM2 (in charge) A deficit of 5 due to sick leave	19 + 1 CNM2 (in charge)	Approx. 178	Numbers up to 191 during the night. Boarders approx. 40 4 SNs provided breaks during a 2-hour period sourced from elsewhere in the hospital. Note these were not EM trained.

There was a short fall of five nurses on the occasion in question.

The funded nursing posts for Zone A, which is where Aoife was sent after triage, were 4. There were 3 nurses available to work in Zone A. Two of those nurses were permanently assigned to taking care of the boarded patients so there was one nurse only to take care of the remaining patients in Zone A, including Aoife, waiting to be seen by a doctor. This was [Nurse].

[17] Source Page 25 SAR Report

[Nurse C] was the [Title] who came on duty in the ED at 8pm on the 17th of December. [They] gave evidence of reviewing the Maxim system when [they] came on duty (page 17) which allowed [them] to identify the numbers of patients. [Their] evidence was that on the evening in question [they] had 15 nurses available, inclusive of [themselves]. [Nurse C's] evidence was that often the [Title] in the ED is often compromised in their role as due to staff shortages the [Title] must take on the tasks of a staff nurse (page 14) (emphasis added):

Q. So you are actually acting as a staff nurse --

A. Absolutely, your role is compromised all the time due to understaffing. You cannot fulfil a role, go to the areas, support the staff, you can't have eyes on -- you can't fulfil that role in a meaningful way at all when you are understaffed, it just doesn't happen because the necessity for somebody to look after a patient that is very sick coming into the department, there is just not the nurse there to do it.

For completeness it should be noted that the allocation of nurses to the ED has since been increased. As mentioned elsewhere, the decision to approve of that increase had been taken in the middle of 2022 but, having regarding to how long it typically takes to recruit nurses most especially from abroad, no additional nurses had in fact taken up their roles by December 2022.

The table below sets out the numbers of nurses allocated to the various areas in UHL's ED on the 17/18 December 2022, the funded posts on that night and the numbers and allocation of nurses to various zones in the ED with a full complement of nurses on a night shift in June 2024-

ED Areas	Staff Nurse Allocations 17/18 Dec 2022	Designated Staffing/ Funded Posts 17/18 December 2022	Nurse Allocation June 2024
Triage	1 CNM	2	2
Resus	3	4	5
Paeds	1	2	3
Zone A	3	4	4
Zones B&C	5	5	5
CDU	1	2	2
EMEWS	N/A	N/A	2
Totals	14(plus 1 CNM2 in charge)	19(plus 1 CNM2 in charge)	23

The hospital provided the Investigation, by email dated the 14th June 2024, with details of the above current numbers of nurses on a night shift and their allocation in the ED. The hospital has confirmed that two of the 23 nurses on duty are permanently allocated to care for boarders in the ED. UHL stated that, while it has been able to recruit staff to meet the allocation from the Safer Staffing framework equating to 21.5 WTE, the challenge

"is in the CNM2 role as we have been unable to fill the 5 WTE post despite advertising since July of 2023."

It is also important to note that, while UHL is able to recruit staff nurses, the hospital does point out that *"the level of ED experience/skill mix is very low. This results in a prolonged training schedule to develop our new recruits."*

It is of concern that, while the hospital does point out that the EMEWS system has been implemented across the ED and is undertaken within the current staffing compliment, *"this can prove challenging with high volumes of admitted patients across the department as staff are deployed to manage."*

As a result of a request from the Investigation, the hospital has also provided figures for the current level of doctors who are rostered during a typical Saturday/Sunday night shift equivalent to that period of time which is the principal focus of this report. The following table sets out a comparison between the number of doctors

rostered on the 17th and 18th of December 2022 and the number who would now be rostered on a similar occasion. It should be noted that both of the sets of figures appearing in this table relate to the full number of rostered doctors. It should be recalled that, on the 17th/18th December night shift, there was one doctor less than the full rostered number available due to a doctor having suffered an injury and being unable to attend.

ED Doctors on Night Shift	17th-18th December 2022	Weekends Presently
Consultants	8am-1pm x1 On-call from 1pm	8am-1pm x 1 On-call from 1pm
Registrars	8am-8pm x 1 10am-10pm x 1 8pm-8am x 2	10am-10pm x 1 8pm-8am x 3
Senior House Officers (SHOs)	8am-8pm x 2 12pm-12am x 1 (absent) 6pm-2am x 1 8pm-8am x 1	2pm-12am x 1 4pm-12am x 1 8pm-8am x 3

(b) <u>The Capacity of the Hospital</u>

The question of the overall capacity of the hospital is relevant to this Investigation in this way. It is clear that severe overcrowding in the ED on the 17th/18th December 2022 was a contributory factor in the ability of all those working in ED on that occasion to carry out their duties in as efficient a manner as possible. The reasons why this is so have been addressed elsewhere. While undoubtedly overcrowding was not the only issue which impacted on the lack of treatment of Aoife on that occasion, such overcrowding was undoubtedly a material factor.

It follows that issues which contributed to that overcrowding are themselves potentially relevant. This Report deals elsewhere with questions concerned with whether, independent of the overall capacity of the hospital, there are measures which could or should have been taken to reduce overcrowding generally. However, that capacity is, for the following reasons, itself, an important issue.

As noted there may, of course, be measures which could be taken to potentially reduce the number of admissions to the hospital, to speed up the length of stay of patients consistent with such patients receiving proper care, and to ensure that patients are discharged as soon as this can safely be done and not delayed in their discharge by reason of external factors. All of these are matters which have the potential to reduce the total demand on hospital beds at any given time.

However, at the end of the day, there is a limit to what even the most effective of such measures can be expected to achieve. The question therefore clearly rises as to whether the capacity in the hospital as a whole is sufficient to absorb all of the patients who need properly to be admitted.

In a separate section of this Report[18], I will address measures which have been adopted in ED since the tragic events of the 17th/18th December 2022 as such measures are clearly material to recommendations which can properly be made. However, the universal view of all of the senior clinicians and managers dealing with ED, as reported to me in interviews, was that the ED itself, with its new level of staffing and assuming the implementation of a small number of additional measures which are planned, would broadly be capable of handling the likely demands placed upon it were it not for the fact that the ED facility itself has frequently to accommodate a significant number of "boarders" being admitted patients for whom beds are not available at the time in question.

In other words it is said that the real ongoing problem into the future stems from the ability to move patients out of ED promptly after they have been admitted to the hospital and no longer need to be in the ED. While there are, doubtless, some measures which could be enhanced to expedite the movement of patients to such beds as are available, it is very clear that the major underlying problem is that there are just not enough beds to accommodate admitted patients.

While the total number of beds which might be needed may potentially be reduced by the sort of improvements referred to in respect of both admission and discharge together with patient flow, there still remains the question of whether, even if all such all matters were optimised, the number of beds within the hospital would be likely to be adequate.

The starting point for consideration of that issue has to be to look at the historical situation at the time of the delivery of Horwath Report. That Report and its relevant recommendations are analysed elsewhere in this Report.

As noted elsewhere, [Senior Staff Member G's] evidence was that the first additional beds which the hospital group received were in 2020. An additional 98 beds were obtained in Dooradoyle with some further beds in Croom.

[18] Chapter 8

In addition to the extra beds already in place, a modular addition is currently underway which will provide 16 extra beds by the end of this year. [Senior Staff Member E's] evidence (page 31 Investigation Interview) was that this 16 bed block was announced by the Minister for Health in recent months and is to be operational by Christmas 2024. [They] did also point out that this modular unit will also have to be staffed.

Furthermore, there is currently under construction a new block which will contain 96 additional beds. The Investigation was informed that it was anticipated that this block would be physically complete by June 2025. There is a question as to whether adequate staffing will be available at that time to enable the block to become operational as soon as practicable after it is ready. As identified in the context of the additional nursing staff approved for ED in the middle of 2022 (but who were not in place by the tragic events of December), it is clear that it currently takes 15 to 18 months from the time when additional nursing staff numbers are approved to nurses being recruited and being actually in a position to work. The Investigation was informed that it has only been in the very recent past that approval was given for the employment of staff to service the new block. Having regard to previous experience, it may well be very challenging to have a full nursing complement in place in time. In that context it does seem to me that there would be considerable merit in questions surrounding the approval of staff numbers being dealt with at the same time as approval for capital expenditure which is needed to construct or adapt premises to provide extra capacity. It is appreciated that there are important differences between capital expenditure, on the one hand, and the long term commitment to current expenditure which arise from the approval of additional staff on the other. However, in a context such as this, the two seem to be inextricably linked. There is little point in building additional capacity if it cannot be utilised because of the absence of staff. There might, in certain circumstances, be a legitimate basis for building a larger facility (due to economies of scale) than could be immediately be staffed but in such a circumstance it would appear sensible that that issue be identified at the time of approval so that the capital expenditure for the development together with an initial number of staff would receive contemporaneous approval with the question of whether and when the full capacity of the constructed facility might be utilised being deferred until there was sufficient funding available to pay the necessary staff needed to allow it to operate at its full level.

However, excluding that particular type of situation, there is little point in building additional capacity unless it can be utilised in a timely fashion. A more joined up approach to putting in place approval for the necessary staff at the same time as approving the capital expenditure for construction seems sensible.

Be that as it may, it does look like the new facility will be fully operational sometime in the latter part of 2025 at the latest. In that context, however, it should be noted that, while the facility will contain 96 beds, the overall programme will lead to a reduction of 25 beds elsewhere in the hospital. That is because some of the current capacity of the hospital is in so called “nightingale” wards. These are the sort of large open wards which formed part of hospitals in the past where a significant number of patients occupied the same ward with, perhaps, only curtains between the respective beds. There are obvious problems with such wards both in respect of dignity and privacy but equally and importantly in respect of the control of infection within such wards. There is no doubt that it is desirable that such wards be modernised but it is equally clear that such a process leads to a reduction in the total number of beds which can be accommodated in a more modern facility within the same space. In this case such developments will mean losing 25 beds in the existing hospital.

Thus the combined effect of the modular build currently underway and the net gain by the opening of the new block should lead to 87 additional beds being in place at least by the latter part of next year.

I also understand that there is approval for a second block of 96 beds which it is hoped can be built by the end of 2027. Hopefully, bringing such a facility into actual operation in a timely fashion will not be delayed by staffing approval issues.

Assuming that facility does come on stream on time it would appear that, by the end of 2027, there should be 183 beds in addition to those currently in use. In that context it is useful to refer to the Deloitte UL Hospitals Group Patient Flow Report of September 2022. This identified that, with the growing, aging population in the region, the bed capacity required by 2036 is an additional 202 adult inpatient beds for the group with an additional 100 beds needed in order to refurbish the ‘nightingale’ wards and reduce the bed occupancy. A total of 302 additional inpatient beds will be required by 2036 according to Deloitte.

In that context, I also understand that there is the potential for a third 96 bed block which is further down the line. However, it would appear that, not least having regard to the need to leave space for a maternity facility which, in accordance with Government policy, should be co-located on a level 4 acute hospital site, there may not be capacity for the Dooradoyle campus to accommodate any further expansion beyond that third new block. While it is beyond the scope of this Report to address such issues in detail, there does appear to be evidence to suggest that there is, therefore, a limit to the extent of which the overall capacity

of the hospital can be increased beyond the additional 183 beds which it is hoped will be on stream by 2027 and the possibility of a further 96 beds at some stage thereafter.

Working back from that limit, it is important, from the perspective of this Report, to identify the consequences for emergency medicine services in the Midwest. It seems clear that it is necessary to assess the likely maximum efficiencies which can be achieved so as to improve admissions and, perhaps more importantly, patient flow and discharge. However, if it is reasonable to project that the number of likely admissions together with the likely stay of such patients, will, having regard to population and demographic issues, exceed the capacity of the Dooradoyle site to absorb such patients, then the problem of the inability of the ED to work appropriately because patients cannot be moved on to beds in a timely fashion, will persist. It should be emphasised that this Report is not indicating any conclusion as to whether that limit does create a problem but it seems critical, given the undoubted leads times which would be involved in implementing any appropriate measures, that research is urgently carried out to identify whether the limitations on the Dooradoyle site are such that it cannot be expanded beyond a number of beds which is below the number likely to be required on even an optimistic scenario concerning admissions, patients stay and discharge. It would appear that such an analysis, should it lead to the view that those limitations do create a long term problem, might well inform decisions as to whether alternative measures need to be adopted to deal with ED demand in the Midwest region. If a conclusion is reached that Dooradoyle cannot, in the medium term, be expanded to a sufficient extent to accommodate admissions arising from ED, then alternative solutions must necessarily be found. It is beyond the scope of this Report to express any views on what those alternative solutions might be.

Finally, in this context, and during the course of the main evidence gathering carried out by this Investigation, I became aware of further announcements concerning capacity in the Midwest Region. The Minister for Health in April 2024[19] announced that a procurement process has been initiated for the operation of the new 50 bed Community Nursing Unit in Nenagh as a step down sub-acute and rehabilitation facility for UHL for one year until the first 96 bed block is opened. The bed profile has been changed in the new block from 48 new beds to 71 new beds. The Minister has asked that recruitment commence 2024 for immediate readiness in 2025. The Minister has mandated that all steps are taken to accelerate the second 96 bed block to be built at UHL and a further 20 permanent step down transition and rehab beds will be procured

[19] **Appendix 15** Department of Health Press Release 4 April 2024

in Clare. The opening hours of the region's three Acute Medical Assessment Units at Nenagh, Ennis and St John's are to be extended to 24/7 on a phased basis and Safe Staffing will be extended to all wards in UHL as per the national rollout. These steps, if they come to fruition, are to be welcomed.

(c) <u>Resources Generally</u>

It is far beyond the scope of this Investigation to deal with broad issues concerning the allocation of resources to and within the Health Service. However, the evidence heard by the Investigation does lead to a small number of observations which are put forward in the hope that they may be of some general assistance.

One question which arose in a number of different respects was a contention, not least by Senior Managers within UHL, that it is under resourced in comparison with comparable other health areas and acute hospitals.

However, I was struck by the fact that there seemed to be broad acceptance that, in the context of those areas of staffing to which it has been applied, the Safer Staffing model provided an appropriate basis for determining staffing numbers. It should be recalled that this model was developed as a result of a report which was designed to devise a method for determining the appropriate level of nursing staff taking into account all relevant factors. [Senior Staff Member E's] evidence on this (at page 20 Investigation Interview):

Q. My understandingis that the increase in nurses was as a result of an objective formula that had been developed as a result of a report?

A. Safer Staffing.

It has already been noted that the National Framework for Safe Nurse Staffing and Skill Mix in Emergency Care Setting in Ireland 2022 resulted in approval for 21.6 WTE[20] additional whole time nurses to the ED, who were not in place at the time of Aoife's death. [Senior Staff Member C], referred to a figure of 21.5 WTE at page 17 of [their] Investigation interview.

[Senior Staff Member E] explained the systems whereby staffing numbers are determined (page 21 Investigation Interview):

So to explain on the two elements, Safer Staffing is very specific. It is definitely calculated through the Department of Health, the Chief Nurse actually, and with the national HSE, HR developed that model and there is a number of nurses on

[20] Page 26 SAR Report

sites who work now and we did get 21.5 so I want to acknowledge that, nurses into the Emergency Department under the Safer Staffing model. That is very well developed and managed by nursing directors and nurses within it. From a doctor point of view or deciding on any other staff member in the hospital, over the years we would be subject to the estimates process it was known as. Every May we would set out what we needed to develop in service in that year and it would be submitted to national HSE who would view it, take a decision, talk with the clinical programmes and decide, a lot of it would be cut away to be honest. That would inform the National Service Plan that would be done annually based on the funding they got from Government after the letter of determination just after the December. So estimates started early. In recent years, in the last four years we are not involved in the estimates process at all. It was put to one side and decision are taken centrally in the HSE as to what services are being developed, what you get in your region and that is the way it has been. This will change again now with the new health region of course, which is good, population based.

[Senior Staff Member C] gave evidence (page 9 Investigation Interview):

Phase 1 of Safe Staffing was funded and supported. There was a certain pot of money, we all applied for it, all the health groups, and we just worked through the process of recruiting. Once you recruit then you go to the next stage. Phase 2 for emergency department. For example we started campaigning for Safer Staffing for our Emergency Department for phase 2 in 2022. The Emergency Department is slightly different, it is based on your attendances and your triage categories and it is based on 2021 figures. At the time there was around 76,000. We now know we are at 80,000. At that time in 2022 in August, September we got approval for 21.5 additional nursing staff.

And at page 10 of [Senior Staff Member C's] interview:

Q. Can I 13just ask, the total figures of nurses that would then be approved as a result of that process, as you mentioned they are based on the number of attendances at the ED Department, would they be consistent throughout the country based on the relative attendances?

A. It is really important to note that because our figures were based on Safer Staffing was 2021. We know there was 76,000 attendees. We knew that that Safer Staffing

has to be reviewed biannually, twice a year, sorry, twice a year, because we know already now in 2023 we saw over 80,000 so we know our attendance has gone up 4,000 to 5,000 so you have to migrate and stay with that.

Q. But the number that is approved is sort of a formula based on the number?

A. It is absolutely a formula based on your attendances, your triage categories and it is very much that formula.

Measures such as Safer Staffing undoubtedly bring both transparency and clarity to decisions on the determination of the appropriate allocation of resources. It is appreciated fully that the implementation of this, or indeed other similar, measures across the Health Service as a whole would take time and might well, indeed, require a gradual increase in the total amount of resources being allocated. However, such measures at least have the benefit of providing a significant increase in transparency in relation to the relative allocation of resources to different parts of the Health Service performing similar functions. If there is an objective basis for determining the amount of resources appropriate to comparable institutions then it will allow an assessment of whether it can truly be said that a particular area or institution is under resourced in comparison with similar areas or institutions taking into account all relevant factors which might impact on the need for resources. The fact that these matters may be capable of being determined objectively does not, of course, mean that the resources for insuring equivalence will necessarily be available, at least in the short or even in the medium term. However, at least such a measure would provide an appropriate starting point for an assessment of where resources need to go and would, hopefully, inform an appropriate public debate.

In the absence of such objective measures, all sides to any particular debate, can, doubtless, pick the figures which suit their case. A, perhaps overly simplistic, example may nonetheless illustrate the point. Assume that, last year, a particular institution only received resources which amounted to 75% of the national average for such institutions, having regard to scale and any other relevant factors, but, this year, received an increase of 20% on last year's allocation whereas the national average only represented a 5% increase. In such circumstances both of the following statements would be true. On the one hand, it might be said that the institution concerned received four times the national average increase in its resource allocation this

year. That would be perfectly correct. On the other hand, it could be said that the institution concerned has an allocation of resources this year which is more than 14% below the national average. That would equally be perfectly true. It is not hard to predict which of those two accurate figures would be put forward depending on which side of the debate (be it funder or funded) the speaker was on. Of course, in passing, it should be noted that it would not be unreasonable to expect the institution concerned to have, nonetheless, improved its performance given the increase in funding beyond the national average but it would equally be unfair to simply emphasise the increase in funding without acknowledging that it still fell short of the national average.

Doubtless, debates on resources allocation will undoubtedly be influenced by a whole range of factors but it must surely be the case that the quality of debate and the quality of decision making thereafter can be only be enhanced by more objective data. It is often said that there are lies, damn lies, and statistics. There is some truth in that for protagonists can pick the statistics that suit them. However, decision making without adequate data is fraught. Objective and readily available data which is based on an appropriate appraisal of all relevant factors (such as that which led to the Safer Staffing Model) can only improve the situation.

A further matter which the evidence suggests might appropriately be placed on a more objective basis is the recognition of what might be termed “medical inflation”. The courts are quite familiar with this topic for it frequently arises in the calculation of damages in serious or catastrophic injury cases where a claimant needs to be compensated for the future cost of medical care. Estimating that additional cost into the future requires an assessment of the rate at which the cost of providing the same service is likely to increase. Experience has shown that normal measures of inflation, such as the consumer price index, do not adequately reflect medical inflation.

It must, of course, be acknowledged that all those operating within the publically funded sector have an obligation to seek ways to make the best and most efficient use of their existing resources. The need to attempt to maximise the use of existing resources due to greater efficiency is an important one. However, the quotation of figures for the increase in the allocation of resources without having regard to medical inflation can be misleading. Saying that a particular medical institution obtained a 5% increase in its resource allocation at a time when medical inflation was running at 7%, actually suggests that the institution concerned has had a reduction in its resources in real terms. The development of an appropriate index or indices to reflect medical inflation on an objective basis would, in my view, be an important contributor to informed public debate. I would leave it to experts to determine whether it would be better that there be a

single index or, perhaps, a separate indices reflecting the mix of expenditure involved in, say, hospitals, on the one hand, and community care, on the other. Obviously any such index or indices would require to be weighted having regard to the expenditure mix in the area concerned including salaries, medicine, equipment costs and the like. However, the development of such an index or indices would, it seems to me, enhance public debate.

A regular complaint from Senior Managers in UHL was that the resources allocation process was essentially reduced to making bids during the budgetary estimate period. Some element of that process will almost certainly be inevitable. However, the legitimate debate that may surround decisions made in that process can, in my view, only be enhanced where there is a greater level of publically available and objectively determined measurement fed into that debate.

CHAPTER 8 - CHANGES SINCE DECEMBER 2022

Given that the Terms of Reference anticipate the making of recommendations, it is clearly relevant to consider developments since the tragic events of December 2022. Some of these are touched on elsewhere in this Report but it is useful to bring them all together to convey a picture of what has, and by implication what has not, changed in the ED with a view to setting the scene for any future developments which may be appropriate.

At an organisational level it is important to note the creation of a new Directorate within UHL which is termed the Urgent and Emergency Care Directorate. In December 2022, as explained by [Dr H], Emergency Medicine was part of the Medicine Directorate which also had responsibility for other specialties like geriatric care for example. Since mid-2023 urgent and emergency medicine, including the ED, has its own Directorate. To place this Directorate in context it is necessary to say a little about the Directorate system of management which operates in UHL. The hospital is divided in to a number of Directorates such as the Urgent and Emergency Care Directorate, the Medicine Directorate and the Child and Maternal Health Directorate. Each Directorate has its own Clinical Director, Director of Nursing, and a Senior Executive/General Manager. Those officials report to the relevant Chief Officers such as the Chief Clinical Director and the Chief Director of Nursing.

In December 2022, the ED was part of the Medicine Directorate. However, in mid-2023 the new separate Directorate referred to above was created with [Dr K] as its [Title]. The Investigation understands that there are regular meetings at which Senior Personnel from each Directorate meet together with the overall Senior Management Team. Thus, each Directorate has, as it were, a seat at the table for those discussions. Doubtless, in circumstances where a Directorate covers a number of areas, the Senior Personnel concerned can raise issues relating to each of the strands of the hospital's activity which come within the remit of their Directorate. However there can be little doubt that having a separate Directorate of urgent and emergency medicine, thus placing those responsible for those areas at the table, must enhance the extent to which issues arising in those areas can be aired at such senior meetings. This development must therefore be considered to be quite a positive one.

There is reference elsewhere in this Report to the difficulties encountered in objectively assessing the needs of patients who might be said to be deteriorating while awaiting been seen by a Doctor in ED and thus might require more urgent attention. As also noted, there is now an objective system (being the EMEWS System)

in place to deal with this issue. That again is a positive development. It should be noted that the implementation of a system such as EMEWS would not have been possible in December 2022 given the then level of nursing posts available. It has proved possible because of the increase of 21.5 Whole Time Equivalent Nurses which, for reasons explained elsewhere, had been approved prior to December 2022 but where the relevant additional nurses were not in place until well into 2023. I am sure that, after the EMEWS system has been operational for a suitable period, an appropriate assessment will be carried out to ascertain its effectiveness. It should be recognised that UHL is among the first EDs in the health service to implement this system.

However, it is of concern that the hospital in June 2024 informed this Investigation that, while that the EMEWS system has been implemented across the ED and is undertaken within the current staffing compliment *"this can prove challenging with high volumes of admitted patients across the department as staff are deployed to manage."*

It is also important to reiterate the position in respect of the overall capacity of UHL. For reasons analysed in some detail elsewhere, it is clear that the overall capacity of the hospital is insufficient, by a significant margin, to meet the demands placed upon it. While measures have been approved to increase that capacity, it must be recognised that there is an inevitable lead time between decision making in that regard and there actually being an operational increase in capacity present on the ground. As noted elsewhere, an additional 16 beds will become available towards the end of this year as a result of the opening of a modular-built unit. Furthermore the net increase of an additional 71 beds is anticipated in, perhaps, the second half of 2025 with the actual date being potentially dependent on the speed at which staff, and in particular nursing staff, can be recruited in sufficient numbers. The Minister for Health's announcements in this regard are contained in the Department of Health Press Release dated the 4th April 2024 annexed at Appendix 16 to this Report. All of these developments are, of course, most welcome but it does need to be recorded that the overall capacity of the hospital as a whole is no greater today than it was in December 2022 although the staffing levels in ED have, of course, improved.

CHAPTER 9 - OVERALL CONCLUSIONS

9.1. The Questions

It is important to start by noting that there are general issues which effect the provision of Emergency Department care throughout Ireland. Many of these issues have been well rehearsed in public debate in recent times and it is far beyond the scope of this Report to seek to provide answers to broad questions which have affected this aspect of the health service for many years. However, it would be unfair to all involved if relevant aspects of those general problems were not at least acknowledged in this Report. University Hospital Limerick is not, of course, immune to those general considerations. In turn, that does not mean that those responsible for decision making in UHL are not potentially accountable for the way in which they have sought to deal with the kind of problems that exist across the board. It would, however, be unfair to those persons not to acknowledge the existence of general problems which impact upon the way in which the hospital in general, and the Emergency Department in particular, operates.

Second, and as already noted, the fact that all hospitals, and in particular all of our emergency departments, may have to struggle against the backdrop of those general problems does not mean that it is not also necessary to look at the specific measures taken within UHL to minimise the effect of those problems on the care received by patients in the Emergency Department. That is the layer of analysis which involves addressing both the corporate and clinical governance of the hospital in so far as it impacts on the way in which the Emergency Department operates with particular reference to factors which may have had some impact on the tragic events to which this Report is directed.

While the particular focus of this Report is, obviously, on the Emergency Department, it is important to acknowledge that this Department does not operate in isolation from the hospital as a whole. One example of this interaction can be seen from the facts set out in the SAR Report. It is there noted that a significant portion of the capacity of the ED facility was taken up by the presence of what are described in that report as “boarders”. That term is a colloquial description of people that have been formally admitted to the hospital but who physically remain within the Emergency Department thus occupying space which might otherwise be available to patients going through the Emergency Department procedures. Those admitted patients are under the care of the relevant doctors appropriate to the conditions in respect of which they have been admitted.

It is obvious that the presence of boarders in the ED stems from the inability to move such patients to ordinary wards. This in turn is clearly caused by a lack of bed capacity in ordinary wards to absorb all admitted patients and, perhaps at least in some circumstances, whether the procedures for moving admitted patients from the ED into beds in ordinary wards are as efficient as they should be. In turn again, the availability of beds in ordinary wards is in part a function of the total number of operational beds available at any stage but also can be affected by the speed with which patients who no longer need to be present in an acute hospital are discharged with this latter factor itself being potentially impacted by the availability of other suitable locations within the health system to which such patients can be moved if they are not ready to be discharged outside of health system itself. All of this goes to show that there are many aspects of the operation of the hospital as a whole which can impact on the availability of beds within the ED. While again, it is beyond the scope of this Report to deal in detail with many of those questions, nonetheless they do form part of the overall picture for they clearly impacted on the availability of resources within the ED on the relevant occasion.

Of more specific relevance to the operation of the UHL Emergency Department itself, it was necessary to consider the way in which that Department operated in general terms but with particular relevance to factors which might have impacted on conditions at the relevant time. Like almost all EDs, a triage system is operated whereby patients are given an initial assessment which is designed to help prioritise those in need of most urgent diagnosis and treatment. It is clear from the chronology set out in Chapter 4 of this Report that the period of time which elapsed between the arrival of Aoife Johnston in the ED to her triage was well in excess of one hour. It is necessary to consider the overall operation of the ED which leads to, at least in some cases, what appears to be a significant delay in even reaching the triage stage. The protocols and procedures in place and the resources allocated need to be considered in that context.

The triage system used in the UHL ED is the so called “Manchester” system. This involves placing patients into one of five categories numbered 1, 2, 3, 4 or 5 where those in Category 1 are assessed as being in need of immediate care. A number of general issues arise in that context. First, the Manchester system is clear that the ideal maximum time to first contact with a treating clinician for a patient assessed in Category 2 (as Aoife Johnston was) is 10 minutes. We know that Aoife was not, in fact, seen for twelve hours. There is also data from which it is clear that there was no reasonable basis, at the time when Aoife first attended and was subject to triage, of her been seen by a doctor within 8-10 hours (if not more). This can be seen from the following analysis. National norms suggests that an ED doctor can see approximately 1.8 patients per hour.

At the time of Aoife Johnston's presentation at the ED and at the time of her triage, there were anticipated to be 3 doctors working in the ED for most of the following period of time. From figures obtained from the hospital, it is clear that, at the relevant time, the number of patients who were ahead of Aoife Johnston in terms of awaiting assessment by a doctor was very substantial being the single Category 1 patient in the ED who had not yet been assessed by a doctor together with those of the Category 2 patients who were adults and who had, as it were, joined the queue before her registration. The system operated by the hospital appears, in general terms, to have involved giving priority to Category 1 patients with Category 2 patients ranking as and between themselves by reference to how long they had been waiting. As described in Chapter 6, there was an ad hoc system whereby nurses might suggest to doctors that a particular patient might be escalated 'up the queue' by reason of a worsening condition. That being said, it follows that the minimum period of time within which it was likely that Aoife could have been seen in accordance with the practice operated by the hospital was completely at odds with the Manchester recommendation of such patients being seen within ten minutes. It was necessary to consider how the system was intended to work in those circumstances.

The figures for numbers of patients present in the ED at the relevant time were provided as a result of a request to the hospital. However, those figures did throw up some further issues which required investigation. First, it would appear that 23 patients who registered after Aoife and were assessed as Category 2 were actually seen before her. However, 6 of these were dealt with in the Paediatric Emergency Department and do not, therefore, form part of an appropriate analysis of the priority given to patients in the adult emergency department. In passing, it should be noted that, as I understand it, in emergency medicine it is generally considered that persons 16 and over are dealt with in what might be called the adult part rather than the paediatric section. In any event, that leaves 17 patients who were escalated to be ahead of Aoife on the occasion in question. The description given by the hospital in respect of those patients was the following: -

- "15 were transferred directly to the Resuscitation room for triage. Of these, 7 were medical presentations (acute stroke x 2, STEMI, seizures, low GCS, PR bleed with shock, acute shortness of breath), 1 was surgical (ischaemic limb), 3 were hip fractures, 2 were ankle fracture dislocations and 1 was a shoulder dislocation. One other patient was likely transferred to the Resuscitation room

as suspected fractured neck of femur, had no fracture, and the ED medical note is timed at 1:45 PM on 18th December 2022.

- 1 was an oncology patient which is believed to have been seen directly by the team.
- 1 was a 77 yo man seen in Zone B with severe pain secondary to acute urinary retention".

The availability of these figures raises other issues. It seems clear that there was some possibility in place to enable patients to be dealt with ahead of the position in which they would have been, had strict adherence to a policy of treating patients within the same category in the order in which they were registered had been followed. There is, of course, nothing wrong in itself with such a practice but it does raise questions as to what categories of patient are escalated in that way and, in particular, who makes the decision to arrange for such an escalation. In addition, it was necessary to enquire as to whether there was any accepted practice governing such escalations or whether they were dealt with entirely on an ad hoc basis. This is of some particular relevance to the case under investigation for it is clear that the fact that those patients were escalated ahead of Aoife had the effect of materially delaying her being seen by a doctor. Likewise, the question arises as to whether, if each of those patients were capable of being escalated, why someone with suspected sepsis and who is subject to a national protocol suggesting treatment within one hour, should not have also been escalated. Finally, in that context, it is worth noting that Aoife herself was, to a limited extent, actually escalated for the figures provided by the hospital show that there were a small number of patients who had registered before Aoife and were placed in Category 2 were actually seen after her.

An additional issue, of a similar variety, arises from the fact that the figures supplied by the hospital indicate that there were 7 non-paediatric patients who were placed in Category 3 but who were seen before Aoife even though there were in a lower category. In respect of those patients it appears that all had been waiting to be seen for periods between 17 and 23 hours. It would appear that the reason why these patients were taken ahead of Category 2 patients was the length of time which they had already spent waiting to be seen. However, this fact does, again, raise issues as to whether there was any guidance about escalating such patients and as to who makes the relevant decision on such escalation. Finally, in that context, it would appear that there were 4 non-paediatric Category 3 patients who were registered after Aoife but were seen by a clinician before Aoife. Three of these seem to have been seen directly by appropriate medical teams other than the Emergency Department team and so do not appear to have had any impact on the speed to which patients were seen in the ED itself. The 4th is stated to have been a patient with shortness of breath

who deteriorated while waiting to be seen with oxygen saturations of 50%. It does not, therefore, appear that the order of seeing of those patients had any material effect on the time at which Aoife was herself seen.

In addition, it is appropriate to note that there were at least two other factors making it likely that the period before Aoife would be seen would in fact be even longer than the rough calculation earlier set out. First, any Category 1 patients presenting while Aoife was in the waiting queue, would be placed ahead of her having regard to the urgency associated with Category 1. Second, there is a significant body of evidence which suggests that the ability of doctors to see patients effectively in a heavily overcrowded ED is such that the average time taken between per patient is significantly greater than that which is indicated by the national average of 1.8 patients per hour. It is clear that, on the occasion in question, the ED was hugely overcrowded so that it was entirely predictable that doctors would find it difficult to meet that national average. Analysis in the SAR Report suggests that, on the occasion in question, the average was very likely to have been below 1.3 patients per hour. This analysis goes to show that there was no possibility, in applying the system operated by the hospital, of someone in Aoife's position being seen within even a lengthy period of time unless she was, in common with the 17 Category 2 patients mentioned earlier, escalated for earlier clinical assessment. That in turn raises questions about the system itself. It is clear that a national protocol in respect of treatment of sepsis suggests a particular bundle of treatment being given within one hour. How the system seeks to reconcile that requirement with the situation where, in the circumstances prevailing on the evening in question, there was no realistic prospect of Aoife being seen within a significant number of hours is a matter which needed to be addressed.

While not strictly speaking relevant to the particular issues relating to the treatment of Aoife, questions may also arise as to whether there are tensions between other national protocols determining the time within which patients who appear to have particular conditions should be assessed, on the one hand, and the operation of the Manchester System with patients of equal category being prioritised mainly on the basis of their time of arrival, on the other hand.

In addition to those issues of process, further questions arose as to how it is appropriate to address the risk that a patient's condition may deteriorate significantly where the gap between triage and assessment is likely to be very long. It is a particularly relevant in this case given that there was ample evidence of concerns being expressed not just by Aoife's parents but also by other patients concerning her materially deteriorating condition. It was necessary to consider what guidance there was as to how such a situation should be dealt

with and, as part of that assessment, to consider who had the role of dealing with such matters and, equally as importantly, who had the authority to ensure that any decision that was made concerning a deteriorating patient was acted upon. It must be acknowledged that these matters can give rise to difficult questions. Obviously moving anyone up the order of priority for being seen by a doctor necessarily involves others being delayed somewhat. If everyone is prioritised then no one is prioritised. However, that does not mean that there may not be appropriate cases in which added priority needs to be given. At the level of clinical and corporate governance it was necessary to access whether, and if so in what way, that issue was addressed in general terms.

In addition to these more general issues as to process and procedures, a further and most detailed, set of questions arise at the level of those who were involved in actual decision making on the occasion in question. Just as it is appropriate to have regard to overall national difficulties in assessing the way in which UHL operates, so also it is appropriate to have regard not only to those general national considerations but also the policies, protocols and resources put in place in respect of UHL when analysing the actions of those who were involved in particular decision making on the night in question. Those who were there on the night can only deal with the procedures and protocols in place at the time and having regard to the resources available to them. It would be most unfair to judge anyone's actions without having full regard to each of those matters. In addition, as already pointed out, it is no part of this Report to attempt to attribute individual blame.

All that being said, however, it was necessary to look at the decisions which were made on the evening in question.

In that context it is necessary to look at the various steps along the pathway from the moment when Aoife registered at the ED at 5.37pm on Saturday evening to the time, some 13.5 hours later, when she was actually treated for sepsis between 7.15am and 7.20am the following morning. The first question concerns the fact that it took well over an hour for Aoife to be triaged. That question arises particularly in the context of a patient who was referred by a GP with a risk of sepsis in the context of the National Protocol which suggests treatment for such patients within an hour. The most significant issue concerns the fact that, notwithstanding Aoife being triaged as also presenting with a risk of sepsis, it was almost a further 11 hours between the time when she was sent to Zone A in the ED to the time when she was actually first seen by a doctor. This again needs to be seen in the context of the fact that, under the Manchester Triage System, patients assessed as being in Category 2 should have first contact with a treating clinician within 10 minutes.

A range of factors potentially impacted on this particular delay. Finally, it is necessary to note that a period of approximately 1 hour 15 minutes elapsed between Aoife being prescribed by a doctor with the sepsis bundle of treatment and that treatment actually being administered.

It is necessary to identify some of the matters which potentially impacted on those delays. There was in place what is described as an escalation plan to “decompress” the Emergency Department when certain thresholds of overcrowding were reached. It would appear that the relevant threshold was reached. However, the escalation plan was not or at least not fully actually activated at that time. It is necessary to assess why that occurred and also to a more general question concerning the resources available to the ED both generally and on the occasion in question. Against the backdrop of those general issues it is appropriate to turn to an assessment of the evidence as to what actually went wrong.

9.2. What went wrong?

There is a sense in which an analysis of the evidence concerning what went wrong in respect of Aoife’s treatment at UHL can be looked at both from a broad general perspective but also in light of certain aspects of the events that occurred on the occasion in question.

The broad perspective stems from the fact that, however one chooses to characterise it, the ED at UHL was grossly overcrowded on the occasion in question. There is no doubt that this was partly due to the fact that there was, even by the high levels of presentations at UHL ED generally, an exceptionally large number of patients requiring to be seen and that a very high number of those patients were, triaged Category 2 and very ill. However, that does not take away from the fact that, even though more serious than on other occasions, overcrowding on a significant scale is, on the evidence, a regular occurrence in UHL.

The general factors which seem to impact on that situation are addressed in Chapter 6. However the one specific factor which relates to the events of the 17th and 18th December 2022 is the failure to implement the decongestion protocol overnight between the 17th and the morning of the 18th. There can be no doubt but that this made what would inevitably have been a bad situation much worse and thus materially exacerbated the difficult conditions in which staff were required to work. The conflict of evidence as to why the protocol was not operated is set out in some detail in Chapter 5.

The Report will shortly turn to what appear to be certain critical steps along the pathway followed in respect of Aoife’s treatment which cumulatively gave rise to the tragic result of Aoife’s death. Many of those steps

were at least contributed to by the extreme pressure under which staff were working. It is for that reason that the failure to follow the decongestion protocol seems to me to be a material factor in any overall assessment. To the extent that it can be said that the pressure under which staff were working contributed to the fact that Aoife was not given timely treatment, then the factors which exacerbated that overcrowding must themselves be taken to be contributory factors. For that reason the evidence establishes that both the factors contributing to overcrowding generally in UHL ED on many occasions and the specific failure to implement the decongestion protocol on the occasion in question did materially contribute to the tragic events.

In respect of the specific pathway followed by Aoife in the ED, the evidence establishes a number of steps which could, and should, have taken place and which might well have led to a more benign result.

The first point on Aoife's journey was the delay between her registering at the ED and being seen by a triage nurse. It is noted elsewhere that patients who arrive by ambulance follow a different pathway, in both physical and organisational terms, when arriving at the ED. However, patients who present in person, whether self-referring or having been referred by a GP, register and take their place in a queue waiting to be seen by a triage nurse. There is no suggestion on the evidence that the triage nurses working at that time were anything but diligent and effective. It follows that there clearly were insufficient resources in triage to enable patients, not least those, such as Aoife, presenting with a referral from a GP which identified a potential condition which in turn mandated early treatment, to be triaged in a more timely fashion. The hospital should consider means whereby more resources can be allocated to triage particularly when the ED is busy especially with patients referred with conditions requiring urgent intervention.

It is accepted that a proper consideration of this issue is not straightforward as taking nursing resources from other areas will itself give rise to difficulties. This is so not least because triage needs to be staffed by experienced nurses given the important role that their judgement plays in the pathway followed by patients.

As already noted, [Nurse A], in this case along with the referring GP, identified potential sepsis and this was recorded on the relevant electronic record. Having seen the system operating during the Investigation's visit to the ED, it would seem that such information is available on the system but it does not seem to be flagged in any particular way so that it would be necessary to pull up the individual form in respect of any particular patient in order to identify the position. This should be addressed by the hospital.

Ultimately, the evidence suggests that none of the nurses or doctors who were working in relevant parts of the ED over the course of the night were aware that Aoife was a suspected sepsis patient. The fact that the sepsis form which ought to be prepared in respect of potential sepsis patients was not filled in in Aoife's case was undoubtedly a significant contributory factor to that lack of knowledge. At the time in question, it seems, on the basis of most of the evidence, that the relevant sepsis forms were only kept in the Resus area. In ordinary circumstances that would not present a problem given that it was normal practice for sepsis risk patients to be sent to the Resus area after triage. However, because that area was already very seriously overcrowded, Aoife was sent to Zone A. That would not, in itself, have presented any particular problem as it is clear on the evidence that Aoife could have, quite effectively, been treated in Zone A had she been seen by a doctor and prescribed the relevant sepsis bundle of medication.

However, the fact that, when Aoife was brought to Zone A, she in effect bypassed the area where the sepsis forms were kept, must have been a significant factor in the lack of knowledge on the part of nurses and doctors in Zone A of her potential condition. This is a particular example of a feature of the number of issues which the Investigation was required to consider. A system may work perfectly well in ideal conditions but may not do so when conditions are more challenging. Obviously, any system no matter how good, will come under pressure in challenging conditions. However it seems important that measures are put in place to minimise the adverse consequences deriving from challenging circumstances while acknowledging that the very fact of those circumstances will necessarily make things more difficult for all concerned. This is particularly important where, as is the case in UHL ED, challenging conditions are a very regular occurrence.

On the visit of the Investigation to UHL ED, it was clear that the sepsis forms are now kept in the triage area so that any patient who is considered to be a sepsis risk will have the form filled out at that stage and thus the problems associated with such form only being available in the Resus area now appears to have been dealt with. I was also informed by [Dr K] that the physical chart for sepsis patients will now have distinctive colouring so as to enhance the likelihood of all concerned being aware of the situation. None of those measures, were, of course, in place in December 2022. The measures now in place would seem appropriate to deal with that problem. However, it is important not to lose sight of the fact that, while the focus of this Investigation is on a patient who presented with a risk of and symptoms consistent with sepsis, there are likely to be other presenting conditions which also require to be flagged. It is recommended that a review take place to identify such other conditions and ensure that similar measures are in place to minimise the

risk of doctors and nurses being, in practice, unaware of the particular risk attaching to specific patients when the ED is particularly busy.

Next it is necessary to consider the period of just short of 11 hours which elapsed between the time when Aoife was sent to Zone A and the time when she was finally been seen by a doctor. There is no doubt, from the account given by relevant nurses, by Aoife's parents and by other persons who were in the ED on the night in question, that, as the night progressed, increasing concern was being vocally expressed by many about Aoife's condition. There is an account in Chapter 6 of the efforts made by [Nurse B] to have Aoife's case escalated. There are conflicts on the evidence as to the precise events which are fully set out in that Chapter. However, whatever be the true situation, the evidence strongly suggests that the problem was exacerbated by the absence of anything other than what can be described as a very ad hoc system for seeking to identify and progress the treatment of patients who are in need of even more urgent attention than others. In saying that, it is important to note the evidence of [Dr F] to the effect that, almost by definition, anyone who is triaged in Manchester Category 2 must be considered to be seriously ill. However, the system which pertained appeared to be simply one that relied on an individual nurse to advocate in respect of a particular patient to a doctor. In circumstances where those doctors were themselves under extreme pressure, and where there was little or no established process, the outcome of such an ad hoc system inevitably depended both on the nurse and the doctors concerned. It is noted that there is now a system in place which places such a process on a much more objective basis. It must also be taken into account that the treatment prescribed for sepsis is relatively straightforward, capable of being administered quickly once determined on by a doctor, and capable of being dealt with in any part of the ED. As this issue was raised with Senior Managers it is further addressed later in this Chapter.

Finally, so far as the pathway is concerned, there is the question of the length of time it took from Aoife being prescribed with the sepsis bundle at approximately 6am on the morning of the 18th, and that bundle being actually administered, which occurred between 7:15 and 7:20. In circumstances where the relevant protocol suggests that a patient should be treated within an hour of being triaged as being at risk of sepsis, it clearly makes no sense if, even after the patient was belatedly seen by a doctor, it took more than that hour for the drugs to be actually administered. The issues surrounding this question are dealt with in Chapter 6.

On the evidence it appears that each of those failures contributed to the overall situation which led to Aoife not being treated for over 13 hours after she first presented to UHL in circumstances where urgent treatment (within an hour) is recommended by the relevant protocol.

Some of the measures which have been adopted since the tragic events of December 2022 may well reduce the risk of similar events occurring in future. However, all of the evidence seems to me to confirm that these risks will not be further minimised without addressing the fundamental problem of overcrowding in ED. As noted in Chapter 7, the position in UHL ED is inextricably linked with the overall capacity of the hospital for a significant part of the problem attaching to the ED stems from the fact that, on many occasions, it is forced to have so called boarded patients, being patients that are admitted to the hospital (and are under the care of relevant specialities within the hospital), and who are physically in ED simply because there are no beds to which they can be moved. Unless and until that problem is addressed (and there is an overview of some of the questions that arise in that regard in Chapter 7), then it seems likely that UHL ED will, unfortunately but regularly, be under pressure and, despite the improvements introduced since 2022, a risk of reoccurrence will inevitably be present.

(a) <u>Questions put to Senior Managers after a review of the evidence</u>

Having reviewed the evidence, I came to the view that there was at least some evidence to support a view that, in a number of respects, there appeared to be a lack of clarity amongst Managers on the ground as to some of the procedures and processes which were in place and which at least had some bearing on the events of the 17th and 18th December.

With that in mind, a standard email was sent by this Investigation to [Senior Staff Member E], [Senior Staff Member G], [Senior Staff Member C] (who at the relevant time was the [Title]) and [Senior Staff Member D] on the 13th June 2024. An addendum email was sent to all Senior Managers, apart from the [Senior Staff Member D], on the 18th of June 2024. A standard form of that email of the 13th May 2024 and the addendum of the 18th June 2024 are included in **Appendix 17.**

In the email of the 13th June 2024 six matters were identified on which the recipients of the relevant emails were asked for their observations. Where appropriate reference was made to the transcript of accounts given to the Investigation by relevant managers on the ground. It should be noted that the email itself acknowledges that not every point might be relevant to the role of each individual member of the

management team but nonetheless it was felt appropriate to include all of the references in each of the letters so that each recipient would have a full overall picture of the queries being raised.

Replies were received from each of the addressees. To avoid any possibility that the text which follows might be considered to fail to adequately reflect each of the replies, the observations concerned are also annexed in Appendix 18 to this Report.

I propose setting out the position in respect of each of the six areas identified in the letter to senior managers and then go onto deal with what appears to be the overall situation having regard to the evidence.

(b) The Operation of the Protocol relating to decongestion in the ED

The starting point has to be to acknowledge, as the email to each of the Senior Managers did, that the evidence supports the view that, as a result of the intervention of the HSE Performance Management Improvement Unit ("PMIU"), it was decided, for a period, that trolleys would not go to wards. It should also be noted that, on the figures, the period concerned (from late July to late October) was one where generally speaking, there were a relatively low number of admitted patients on trolleys on any event. However, as analysed in Chapter 5.1 (d) of this Report, it is clear that there were some occasions when the relevant protocol would, during that period, have suggested that ward trolleys should be used but where they were not. Thus it would have be clear to all concerned that the protocol was not been applied and, on the evidence, it seems clear that the managers on the ground understood that being as a result of the intervention of the PMIU.

It is also clear that, at a so called Extraordinary Meeting on 22nd October 2022 a decision was made to re-instate the practice of trolleys being placed on wards in circumstances where the protocol thresholds for a number of trolleys was reached. There is, therefore, no confusion as to what the position of the Senior Managers actually was. They went along with the suggestion of the PMIU up to late October but that position was reversed on the 23rd with ward trolleys being used from then on. It should be recalled that [Senior Staff Member E] was not involved in the initial decision but had returned to work by the time the October decision was made.

The issue is not, therefore, as to whether there was any lack of clarity amongst Senior Managers about both the position between late July and late October and the position after the Extraordinary Meeting in late

October. Rather the position is as to the extent to which those changes in policy were adequately communicated to managers on the ground so as to avoid any confusion about what the situation was.

There is no doubt that the protocol is clear in its terms. However, there is equally no doubt that it was not actually applied for a period of almost three months but then was, to a significant extent, applied again. However, having regard to the analysis of numbers on trolleys in the period between late October and the events of the 17th and 18th December as set out in Chapter 5, it is not clear that the protocol was universally applied during that latter period. It should also be said that some managers on the ground referred to the position of the PMIU while others also referred to the position adopted by the INMO and to the fact that there was often resistance from nurses serving on wards to the idea of ward trolleys being used.

It is correct to state that some Senior Managers question some of the language used in the transcript quotations supplied to them. Be that as it may, the overall evidence suggests that, while the position of Senior Managers themselves was clear, there remained a lack of clarity among managers on the ground as to just how the protocol was to operate at least in the period after October 23rd. The situation would undoubtedly have benefited by greater clarity being given to those managers as to the effect of disapplication of the protocol for a three month period followed by its reinstatement, at least in many cases thereafter.

While it is fully appreciated that the question as to why the protocol was not operated on the 17th and 18th of December is one in respect of which there is a significant conflict of evidence, nonetheless, that situation does, at least potentially, appear on the evidence to have been impacted by the lack of clarity to which I referred.

To reduce the possibility of a similar situation arising in the future it is recommended that the communications systems in UHL and the wider hospital group are reviewed with a view to ensuring that when important decisions are made at Senior Management level they are effectively and clearly communicated to managers on the ground.

(c) The Role of Executive on-Call in relation to decongestion

Each of the Senior Managers point to the fact that the overall responsibility for the implementation of the escalation protocol lies with the Operational Assistant Director of Nursing and that the position of the Executive on-Call is one of support and advice. That formal position is undoubtedly clear on the evidence.

However, that fact of itself does not take away from the evidence from a significant number of nurses on the ground which suggested that it was their belief that the matter was ultimately for the Executive on-Call.

There again appears to be a difference between the clear and accepted policy at Senior Manager level and the understanding of the on the ground managers of what the situation in practice was expected to be. In the course of [their] evidence, [Senior Staff Member B] referred to the fact that there had been a series of questions posed by a national newspaper which implied that the decision not to deescalate may well have been [theirs]. Obviously, the underlying premise of those questions was incorrect in that it is clear on all the evidence that it was not [their] decision at all. However, it must be inferred that someone made the suggestion to that newspaper that the situation was otherwise. It would be impossible to ascertain the relevant source of information. However, the suggestion that [Senior Staff Member B] had a significant decision making role in respect of decongestion is one which appears across much of the evidence given by nurses involved on the occasion in question. It follows that it is not clear on the evidence that the respective roles of the Assistant Director of Nursing and the Executive on-Call was made clear to all concerned not withstanding that fact that there may well have been clarity about the respective roles at the level of Senior Management.

(d) The Sepsis Forms

[Senior Staff Member D] expressed regret that the sepsis forms were not in triage. It does appear on all the evidence to be the case that the relevant forms were only kept in Resus at the time in question and that this was the general practice. I have not been provided with any explanation as to why that practice was followed. Neither have I been provided with an explanation as to why it was not recognised that following that practice would run a risk in respect of sepsis risk patients in circumstances of significant overcrowding where the ordinary practice of such patients going to Resus might not be capable of being followed.

(e) The Process for Category Two patients being seen by doctors

Both [Senior Staff Member G] and [Senior Staff Member E] indicated that, in their view, this was a matter for [Senior Staff Member D]. [Senior Staff Member D] makes clear that strict chronological order (in the sense of patients within a triage category being ordinarily seen in the order in which they presented) is no substitute for clinical judgement. The expert evidence available to me would undoubtedly agree. However, [Senior Staff Member D] also draws attention to the difficulty in exercising the relevant form for clinical judgement which

might be needed where the numbers, and indeed the acute nature of, patients presenting made it very difficult for anyone to exercise an overall view of the Category 2 patients within ED.

The evidence supports that contention given that the senior registrar spent [their] entire shift working on acute cases in Resus while the other registrar who was present for the night shift in full spent part of [their] time also in Resus (noting the different recollections referred to elsewhere as to what proportion of [their] shift was worked in Resus).

[Senior Staff Member D] is also, undoubtedly, correct when [they say] that the resources were not present at that time to adopt a system such as the EMEWS system which is now in place. It may well be, therefore, that there was little more than could be done in light of the very large number of Category 2 patients and the very small number of doctors present to treat them. The only additional point stems from the fact that Limerick ED has been very crowded on many occasions (even if not always at the extreme level experienced on the occasion in question).

That problem, of senior Registrars being unable to exercise proper clinical judgement as to priority, may well have arisen previously and there does not appear to be any evidence as to any established practice having been in place as to what was to happen in such circumstances. This Investigation notes the position in relation to [Dr F] as set out in the SAR Report. It should be noted that [Dr F] was not asked to come in to see Aoife but rather was asked to come in by reason of the extremely overcrowded nature of the ED.

[Dr F] at [their] interview (page 23 and 24) drew attention to the guidance provided by the Royal College of Emergency Medicine which does clearly specify that it is not the role of the Consultant on-Call in an Emergency Department to come in simply because of numbers issue, they attend on a case by case basis and if the major emergency plan is activated. This states that *"Consultants are 'on call' to deliver expertise in clinical areas beyond the experience/skill level of resident clinicians. This enables cost effective delivery of senior clinical expertise. By definition therefore, tasks that do not require senior clinical expertise e.g. acting-down to cover staff absence, are not 'on call' responsibilities and must be addressed via other mechanisms. Where capacity deficits have created queues, these too should be addressed through standard operating procedures that mobilise other clinicians within the hospital or redirect appropriate patients to medical, surgical or paediatric assessment units. Good risk management should seek to maximise resources available to deal with such problems, and avoid concentrating multiple risks in a single area."*

However, there may be circumstances when a situation might benefit from someone who could exercise an overall view as to priorities where all of the doctors on the ground were fully taken up with treating acute patients. I would do no more than echo the recommendation of the SAR Report that the roles and responsibilities of the EM Consultants on call be reviewed and add that clarity should be brought to the question of if, and if so when, it might be appropriate for the Consultant on call to attend, not for the purposes of providing an additional pair of hands when the ED is under pressure, and not, obviously, where such a consultant is required to come in where there particular expertise is required for an individual patient, but where circumstances might warrant a Senior Clinician who is not dealing with individual patients being in a position to exercise an overall view.

Without clarity on that issue, it is important to note [Dr F's] evidence which was to the effect that Limerick ED was so regularly overcrowded that a Consultant on Call would, if overcrowding were the sole trigger for their attendance, be required to be in attendance on a very large number of occasions, beyond what might be described as their regular duties as an On call Consultant.

(f) Obligations of the Executive on-Call follow-up

[Senior Staff Member G] re-iterated that it was for the [Senior Staff Member A] to deal with the matter. [Senior Staff Member D] indicated that [they] felt the [Senior Staff Member B] could reasonably expect that what had been agreed with the [Senior Staff Member A] would actually occur. [Senior Staff Member E] made reference to the Trigger Process Flow Plan (as referenced in the Escalation Plan) requiring notification to the Executive on Call of the implementation of the Escalation Plan from step 3 onwards. [Senior Staff Member E] notes that [they accept] that the Operational Assistant Director of Nursing regularly contacted the Executive on Call to give notice of the implementation of the Escalation Plan by moving trolleys to wards. This does not appear to have occurred on the 17th/18th December 2022.

[Senior Staff Member B], when this was put to [then], reiterated [their] position that [they] had one call on the 17th December 2022 with [Senior Staff Member A] where a plan of action was agreed. [Senior Staff Member B] was not made aware of any barriers to implementation thereafter.

(g) The Co-ordination of the Role of Doctors in ED

Both [Senior Staff Member E] and [Senior Staff Member G] indicated that this was a matter for [Senior Staff Member D]. [Senior Staff Member D] describes the position but does not really make any comment on the potential question of whether there was, if not a lack of clarity, then a difficulty in circumstances where the pressure on all doctors to treat patients was such that additional oversight or coordinative roles were unlikely to be capable of being fulfilled. This is, perhaps, another example of a system which would be likely to work reasonably well, in ideal or normal conditions, but where additional difficulties might foreseeably arise in challenging conditions. Acknowledging, as one must, that difficulties will inevitably arise in challenging circumstances, nonetheless, it might be appropriate for the future, to give some thought as to whether it would be useful to have guidance as to what is to happen in such challenging circumstances.

9.3 Recommendations:

1) Steps should be taken by the HSE to determine whether there are circumstances in which it could be recommended that a GP, on identifying a risk of sepsis in a patient, takes the initial treatment steps required at that time while also referring the patient to an ED for further assessment and, if necessary, additional treatment.

2) Consideration should be given by the HSE to identifying whether there are ways in which patients who attend at the Emergency Department and who are potentially in need of urgent treatment, but who do not arrive by ambulance, can be assessed in triage more quickly, instead of having to wait in a queue system;

3) A review should take place to seek to identify whether there are ways in which more resources could be allocated to the triage system in the ED in UHL in circumstances where demand, in the shape of presenting patients (and especially those referred with conditions requiring urgent intervention), requires same.

4) A review should take place to seek to identify whether there are ways in which more resources could be allocated to the EMEWS system in the ED in UHL in circumstances where the hospital has told this Investigation in June 2024 that this system is staffed from the current staffing compliment but that

this is already proving challenging when there are high volumes of admitted patients across the department.

5) It would seem information is available on the electronic system used in the Emergency Department which notes if a patient is identified as query sepsis either by a GP or the triage nurse. The system does not seem to be flag this in any particular way so that it appears to be necessary to pull up the individual screen in respect of any particular patient in order to identify the position. This should be addressed by the hospital to ensure that once a patient, presenting with symptoms that point to a serious condition like sepsis which requires prompt treatment, enters the hospital system, this is highlighted and immediately evident on the electronic system and all paper records, without a clinician or nurse having to open the individual detailed screen.

6) A review should take place to identify such other serious conditions, apart from sepsis, that require prompt treatment to ensure that measures are in place to minimise the risk of doctors and nurses in the ED being, in practice, unaware of the particular risk attaching to specific patients when the ED is particularly busy.

7) A patient, once seen and prescribed medication by a doctor, should not be waiting over an hour, as happened here, for those medications to be administered. Equally the ad hoc system of a doctor asking a nurse in a busy ED to administer a prescription to a patient with no prompt follow-up is unsatisfactory. It is recommended that a full review of the system in the ED in UHL for the administration of all prescribed medications (not simply medications prescribed for symptomatic relief) should take place in order to obviate the risks of delay once medication is prescribed.

8) A review should take place to ascertain whether there are additional measures which could be adopted to ensure that the Resus area is, to the greatest extent possible, used only for patients whose clinical requirements necessitate their being in such an area in order to ensure proper patient management.

9) It is clear from the figures presented to this Investigation that the Emergency Department in UHL has a higher number of presentations and a higher percentage of presentations resulting in admissions than other Model 4 hospitals nationally. The HSE should commission a detailed study on this in order

to better understand the reasons and possibly put systems in place in the community to reduce the level of presentations, admissions and the consequent pressure on beds in the Dooradoyle site.

10) It is recommended that the communications systems in UHL and the wider hospital group are reviewed with a view to ensuring that, when important decisions are made at Senior Management level, including on the operation of protocols or otherwise, these are effectively and clearly communicated to managers and staff on the ground.

11) The roles and responsibilities of the EM Consultants-on-call should be reviewed and clarity should be brought to the question of if, and if so when, it might be appropriate for the Consultant on-Call to attend, not for the purposes of providing an additional pair of hands when the ED is under pressure, and not where such a consultant is required to come in where their particular expertise is required for an individual patient, but where circumstances might warrant a Senior Clinician who is not dealing with individual patients being in a position to exercise an overall view on the situation in the Emergency Department.

12) A review should take place of the coordination of the roles of doctors in the ED, in particular when the ED is busy and all doctors, have many patients to attend to. Consideration should be given to the need, in such circumstances to have a senior doctor present at an appropriate time to form an overall clinical view of the Department and co-ordinate doctors as necessary during such busy periods.

13) Objective measures (much like Safer Staffing) should be applied in determining the allocation of staff and resources across the health service in order to increase efficiency and transparency.

14) The development of an appropriate index or indices to reflect medical inflation on an objective basis should be considered in order for the health service to plan and to improve accountability and properly inform public debate.

15) Consideration should be given by the HSE, the Department of Health, and the Department of Finance to questions surrounding the approval of staff numbers being dealt with at the same time as approval for capital expenditure which is needed to construct or adapt premises to provide extra capacity within the health service. Capital expenditure and the long term commitment to current expenditure which

arise from the approval of additional staff seem to be inextricably linked in a functioning health service. There is little point in building additional capacity if it cannot be utilised in a sufficiently timely fashion because of the absence of staff.

16) The evidence provided to this Investigation points to the UHL hospital site in Dooradoyle coming close to capacity in terms of built infrastructure. The evidence also points to a growing, ageing population in the region with increasingly complex health needs. Research should urgently be carried out to identify whether the limitations on the Dooradoyle site are such that it cannot be expanded beyond a number of beds which is below the number likely to be required on even an optimistic scenario concerning admissions, patients stay and discharge. It would appear that such an analysis, should it lead to the view that those limitations do create a long term problem, might well inform decisions as to whether alternative measures need to be adopted to deal with ED demand in the Midwest region. If a conclusion is reached that Dooradoyle cannot, in the medium term, be expanded to a sufficient extent to accommodate admissions arising from ED, then alternative solutions must necessarily be found.

17) This Investigation was commissioned following the tragic death of Aoife Johnston in UHL on the 19th December 2022. The HSE should, if and when the Johnston family consider it appropriate, liaise with the family with a view to memorialising Aoife.

CHAPTER 10 - SOME GENERAL OBSERVATIONS ON INQUIRIES AND INVESTIGATIONS

There are a number of general observations concerning Inquires or Investigations which it is appropriate to record in this Report for they inform some of the decisions made as to what can and cannot be done within the parameters of an Investigation such as this and also what types of recommendations it might be appropriate to make in reports such as this.

There are a number of often competing, and sometimes incompatible, demands when any Inquiry or Investigation is being set up. Obviously the underlying need for an Inquiry or Investigation stems either, in the public domain, from concerns about issues of public interest, or, in the private domain, concerns about the operation of an organisation, corporation, or the like. Obviously, in some cases, there are overlapping public and private concerns at play.

These concerns give rise to a demand both for a speedy resolution to the process, as comprehensive a review as possible while at the same time providing a result which may give rise to significant consequences. The potential tension between these competing demands has often been commented on before but is worth repeating here. (See, for example, Byrne *"Political Corruption in Ireland 1922-2010-A Crooked Harp",* at pages 175-181, where the comments, although specific to Tribunals of Inquiry, are also relevant to most forms of Investigation or Inquiry.)

While there may be an understandable desire that an Inquiry or Investigation, and its conclusions, be as wide ranging as possible, there is an obvious tension between that requirement and the need to obtain answers or recommendations within an appropriate and relatively short time frame. In that context, the range of issues which fall within the scope of the Inquiry or Investigation plays an important role. While it is understandable that those formulating the relevant Terms of Reference concerning scope (and those who seek to influence their formulation) may often wish for the widest possible range of issues to be included, experience has often painfully demonstrated that the price that is paid for overbroad Terms of Reference is a prolonged process which often produces results at a significant remove from the events concerned and which can, therefore, impair, sometimes significantly, the benefit of any recommendations made. It should be said that, in the context of this Investigation, no problems were encountered arising from overbroad or unclear Terms of Reference.

Next there is a tension between the desire for particular types of results, on the one hand, and the need for a timely conclusion to the process on the other. Where a process has in contemplation the possibility of adverse findings in relation to individuals, then the requirements of constitutional justice mandate that those who may become the subject of such findings are given a full opportunity to know the evidence and materials which may ground such a finding, to be given an opportunity to present their own side of events and, where necessary to challenge adverse evidence by cross examination and have the right to make submissions or observations on the type of conclusions which might be reached. In the Civil Court process, these requirement are met by requiring the parties to plead their case in some detail, by the frequent obligation to disclose in advance of a hearing any documentary evidence that may be relevant and by the increasingly frequent requirement to give notice of the evidence likely to be given by witnesses. All of that evidence and argument is then subject to detailed analysis and, where appropriate, to challenge at a hearing at which all parties are represented. However, that Civil Court process typically involves two or only a small additional number of parties. Some Inquires or Investigations may closely mirror that situation where what is involved potentially reflects adversely on only one or a few persons. However, many Inquiries and Investigations are necessarily more wide ranging and potentially involve the interests of many persons. Different models have been adopted to seek to ensure that fair procedures are followed in such circumstances while at the same time minimising the length of time which the overall Inquiry or Investigation is likely to take. Modular hearings can, for example, remove the necessity of persons being involved in aspects of the process which do not directly affect them. However, the usually broad ranging and potentially broadly affecting nature of some Inquires or Investigations mean that a hearing at which all interested parties are represented (whether modular or otherwise) is not really suitable. Thus many Inquiries and Investigations involve the interview of individuals on perhaps more than one occasion.

However, it is of the utmost importance to emphasise that, where that model of separate interview is adopted, it does not remove the obligation to ensure that any person in respect of whom adverse individual findings might be made are given a full opportunity to challenge any evidence which might potentially give rise to such findings, to present their own evidence and to make submissions on what might be the appropriate result so far as the Inquirer or Investigator is concerned. In a similar context, where it is necessary to resolve disputed questions of fact, it is impossible to move away from the requirement and that those who might be adversely affected by a particular finding of fact must be given a full opportunity, in accordance with the case law, to challenge the evidence which might give rise to such a finding.

In all those circumstances, it is inevitable that an Inquiry or Investigation which is charged with making individual adverse findings and resolving disputed questions of fact will necessarily take a great deal longer than one that does not have those roles. In such a case the Inquiry or Investigation has to assemble the evidence which might give rise to such a finding and identify the person or persons who might be affected. Those persons must be given the opportunity to challenge, dispute, or make submissions on that evidence and present their own case. Frequently, the presentation of that "Defence" case requires putting matters raised back to those who gave the initial evidence in the first place and often a lengthy iterative process along those lines continues.

Just as over broad Terms of Reference can lead to an interminable process so also must it be recognised that there is no way around the procedural safeguards which need to be put in place if the Inquiry or Investigation is to resolve disputed questions of fact and make individual adverse findings. A choice must ultimately be made. It is not possible to have it both ways and have a timely resolution while at the same time complying with the obligations of procedural fairness. That being said, these tensions do not necessarily give rise to a zero sum game in which each increase in either scope or capacity to make adverse findings give rise to an equal and opposite effect on time. It is possible to mitigate some of these tensions by adopting an appropriate process. It will be necessary shortly to turn to how that might be done in the context of this Investigation.

In addition, it is appropriate to comment on the fact that it is sometimes said that the involvement of lawyers representing parties is an impediment to the proper conduct of such Investigations. If, it is sometimes rhetorically asked, people have nothing to hide why do they need lawyers. It would, of course, be naive not to acknowledge that there may well be cases where persons instruct lawyers to represent their interests precisely because they may legitimately fear adverse findings. However, there are a number of comments which should also be made in that context. First, it may properly be said that there can be a significant degree of nuance about any report which an Inquiry or Investigation may make in respect of any a particular issue. Sometimes issues are not black and white. It is, for example, entirely reasonable, in certain circumstances, for a person to accept that things might have been done better without conceding that some of the more serious accusations which could potentially be made are well founded. To put things in a colloquial way, it should be possible, in an appropriate case, for someone to put their hands somewhat up without having to

raise them to full height. It is appropriate to note that almost all of those interviewed by this Investigation chose not to require legal representation (see Appendix 2).

Second, it does have to be noted that, where the report of an Inquiry or Investigation is not perceived, whether rightly or wrongly, to be sufficiently hard hitting, it has frequently been the case that the Inquirers or Investigators are subjected to public criticism. Hopefully, the fact of such criticism does not influence Inquirers or Investigators in their work (out of fear of being subjected to similar criticism if the report is not believed to be sufficiently hard hitting) but it is difficult to avoid the possibility that someone who may be the subject of an Inquiry or Investigation might reasonably entertain such fears. Just as it would be naive to think that some of those who "lawyer up" want to prevent the truth coming out, it would be equally naive not to accept that others may wish to seek to mitigate the risk or fear that the reporter might, subconsciously, be influenced by a desire to avoid criticism for not being sufficiently hard hitting.

A number of points need to be made about this Investigation in the context of the previous remarks. First, the Terms of Reference specified a time period of eight weeks although that period could be extended. It must be inferred that the intent was that this would be a timely Investigation which would not take a very lengthy period. The Terms of Reference require Investigation of the particular circumstances pertaining to the events leading to the tragic death of Aoife Johnston but also as to extent of which clinical or corporate governance may have created circumstances that contributed to those events. The particular circumstances were the subject of a significant analysis by the Review Group which has previously reported. The availability of both the SAR Report and the materials on which that report was based, clearly had the significant benefit of greatly shortening that aspect of the process which involved investigating those primary facts. However, it is abundantly clear that it would not have been possible to conduct the sort of process which might give rise to the possibility of adverse individual findings in anything remotely like the time scale specified in the Terms of Reference. In those circumstances, it was indicated at an early stage that a provisional view had been formed to the effect that the report would not contain individual adverse findings.

If this Investigation were to be of a type where it was intended that such findings might be made, then it would necessarily have given rise to a very time consuming Investigation which would have lasted very many multiples of the eight weeks specified. Where, as here, the report touches on issues of governance in respect of an ongoing hospital operation, then clearly a timely report is of considerable benefit not least for anyone who might themselves find their situation improved by any recommendations that might be made but who

would not be able to avail of any such benefits if the recommendations were greatly delayed. Nothing has happened in the intervening period, since I gave that initial indication, to cause me to change my view that the making of individual adverse findings is outside the scope of an investigative report of this type. For similar reasons, it does not seem to me that it is open to me to attempt to resolve any disputed factual matters other than to record the competing evidence.

The experience of this Investigation is illustrative of the type of issues which can arise where, for good reason arising not least arising from the large number of persons with a potential interest in the matters set out in the Terms of Reference, a series of interviews, rather than a “set piece” hearing, was the method adopted.

As noted elsewhere, a significant procedure had to be adopted in respect of those issues where a conflict of evidence emerged. This required going back, often on multiple occasions, to those persons who had given the evidence concerned to ensure that all had a reasonable opportunity to ensure that their side of the case was fully and fairly set out in the relevant sections of the Report. Indeed, as noted, it was felt appropriate, in respect of those areas where there was a conflict of evidence, that a first draft of the part of the report dealing with such conflicts should be sent, in each respective case, to those persons who had given the conflicting evidence. Failure to adopt those, or similar, measures would undoubtedly have exposed any report to the risk of being legitimately criticized, or even challenged, on the basis of having failed adequately and fairly to set out the respective positions of the persons involved. However, inevitably, adopting such procedures lengthens the process to a material extent and ensures that, even after a reasonably advanced preliminary draft has been arrived at, significant further time needs to be spent to conduct that process so as to ensure overall fairness. It should be noted that the observations made during that latter process did lead to some material changes in the text in the interest of fairness.

Finally, in this same context, it should be noted that the requirement of fair procedures is that the substance of any matter in which a person may have a legitimate interest should be put to them in some fashion in the course of an investigation so as to ensure that they have a reasonable opportunity to make their own observations and give their own evidence. There is no hard and fast rule as to the method which must be is adopted for doing this provided that it is, in an overall sense, fair. In some cases, a practice has been followed which involves supplying parties with drafts of a full report, or significant parts of same. However, that practice has, in some cases, led to leaks of the report occurring with, doubtless, a view on the part of those leaking the report that they may be able to control the narrative by so doing. There may well be cases where

furnishing a draft of all or significant parts of a report is the appropriate procedure to follow but it is not necessary. In the case of this Investigation, the procedure followed was to inform relevant parties of the substance of any evidence which might affect them and give them an opportunity to make observations and also, in the limited areas where there was a conflict of evidence, to supply those involved in that conflict with an initial draft of what might be said in the report in respect of the conflict concerned.

The fact that a number of quite significant disputed questions of fact emerged in the course of the Investigation had the effect of lengthening its duration significantly beyond the 8 weeks originally envisaged. As noted, the process adopted in respect of such conflicts was to attempt to set out in a full and fair way the competing accounts without seeking to offer a view on where the truth might lie. While those factors did, indeed, of themselves lengthen the duration of the Investigation, it must also be said that, had it proved necessary to seek to resolve those conflicted issues and also to apportion blame, the process would have taken much longer again for it would have been necessary to put in place significant procedures, probably involving hearings at which parties would be represented and be entitled to cross-examine, before such conclusions could be reached. On that basis, and having regard to the fact that the Investigation was in any event taking longer than anticipated, I saw no reason to alter the initial view that it would be inappropriate to seek to resolve issues of contested evidence or to attempt to apportion blame.

It is finally necessary to say something about conclusions. As noted earlier in this section, over broad Terms of Reference can come into serious tension with the need for an expeditious report. However, that does not mean that there are not ways in which such tensions can be mitigated. Where issues emerge in the course of an Investigation such as this which would merit further consideration, it seems appropriate that, rather than prolonging the process, the report can properly recommend a particular course of action for dealing with the matters identified. There can, in the context of an Investigation such as this, be an added reason for such an approach. Issues can and do arise which involve the allocation of resources, industrial relation issues and other matters which are, potentially, both beyond the scope of an Investigation such as this but also may require the bringing to bear of different expertise. To take but one example, it is easy for an Investigation such as this to identify where additional resources might have improved matters but the allocation of finite resources inevitably involves decisions which prevent some resources being allocated in other directions. Often difficult choices have to be made as to where best and where fairest to allocate resources. I do not envy the task of those charged with making such decisions. However, in the broader

process which leads to such decisions, all those who might be affected can at least attempt to have their voice heard even though, doubtless, some may complain that their voice is not heard loudly enough. The problem, which confronts an investigation such as this is that the voice of those who might be adversely affected by any decision to implement a recommendation concerning the allocation of additional resources will be not be heard at all. That does not mean that, where it is clear that the lack of resources formed a part of the overall problem, it is not incumbent on the report to identify this fact, and, as it were, throw its weight behind the need to give serious consideration to the relevant resources issue. However, to make a positive recommendation which might realistically affect how resources were allocated in other areas could give rise to an obvious unfairness in circumstances where those who might be affected by resources being redirected do not have their voice heard.

In summary, therefore, the analysis contained in this section leads to the following approach in the context of this Investigation: -

A. It is not within the scope of this Investigation to resolve disputed issues of fact. Rather, to the extent that any such issues arise, the Report simply records the competing evidence;

B. The Report does not contain individual adverse findings in respect of any persons. That does not mean that the recommendations may not, to a greater or lesser extent, have a potential impact, in general terms, on those involved. As is set out in more detail in the process section to this Report, procedures were put in place to ensure that those who might be indirectly affected in that way were afforded fair procedures;

C. Where matters were identified that are of potential relevance to an overall assessment of the issues but which go beyond the particular focus of events which reasonably directly impacted on the circumstances leading to the tragic death of Aoife Johnston, such matters are dealt with by making appropriate recommendations as to further steps or research which, in my view, should be taken.

Dated the 10th July 2024

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Frank Clarke

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APPENDIX 1

Terms of Reference

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

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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 4.6 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.

APPENDIX 2

List of persons interviewed

1. Mr James Johnston and Mrs Carol Johnston: Interviewed 17th January 2024; represented by Mr Damien Tansey Solicitor and Ms Marie-Claire Burke Solicitor

2. [Senior Staff Member B]; Interviewed 23rd February 2024; represented by Solicitor, Hayes McGrath

3. [Nurse C]; Interviewed 23rd February 2024 & 22nd March 2024; accompanied by an INMO representative

4. [Staff 15]; Interviewed 23rd February 2024; accompanied by an INMO representative

5. [Nurse E]; Interviewed 23rd February 2024 & 22nd March 2024; accompanied by an INMO representative

6. [Senior Staff Member A]; Interviewed 4th March 2024; accompanied by an INMO representative

7. [Nurse D]; Interviewed 13th March 2024; accompanied by a SIPTU representative

8. [Health and Social Care Professional Staff Member A]; Interviewed 14th March 2024; attended alone

9. [Dr D]; Interviewed 14th March 2024; attended alone

10. [Dr A]; Interviewed 19th March 2024; attended alone

11. [Senior Staff Member K]; Interviewed 19th March 2024; accompanied by a SIPTU representative

12. [Staff 25]; Interviewed 22nd March 2024; accompanied by an INMO representative

13. [Nurse F]; Interviewed 26th March 2024; attended alone

14. [Nurse A]; Interviewed 5th April 2024; accompanied by an INMO representative

15. [Dr C]; Interviewed 5th April 2024; attended alone

16. [Nurse B]; Interviewed 9th April 2024; accompanied by an INMO representative

17. Members of Performance Management Improvement Unit (PMIU) interviewed 17th April 2024

18. [Senior Staff Member C]; Interviewed 29th April 2024; accompanied by an INMO representative

19. [Dr B]; Interviewed 29th April 2024; attended alone

20. [Senior Staff Member G]; Interviewed 1st May 2024; accompanied by a colleague

21. [Dr F]; Interviewed 7th May 2024; attended alone

22. [Dr H]; Interviewed 7th May 2024; attended alone

23. [Senior Staff Member D]; Interviewed 8th May 2024; represented by Counsel and Solicitors

24. [Senior Staff Member E]; Interviewed 8th May 2024; represented by Counsel and Solicitors

25. [Senior Staff Member H]; Interviewed 8th May 2024; attended alone

26. [Health Care Support Staff Member A]; Interviewed 13th June 2024; attended alone

APPENDIX 3

Standard Form Letter

Dear X

As you may be aware, I have been appointed to carry out an investigation into issues arising from the tragic death of Aoife Johnston in University Hospital, Limerick. I enclose herewith a copy of the Terms of Reference of the investigation.

I understand that you had a meeting with the Review Team, which previously considered and reported on the issues, and that a transcript of what was said at that meeting has been kept. That transcript has been furnished to me as part of the materials to consider in the context of my investigation. I enclose a copy of that transcript.

My purpose in writing to you at this stage is to ask you to review the transcript and having read same to consider if there is anything you would wish to add, clarify or alter. My purpose in asking you to do this is so that I might have a complete account of what you know about the relevant events. Subject to such changes as you might wish to make, I propose treating that transcript as evidence in my investigation. In the event that you do wish to make any alterations, then I am happy that you can do so either in writing or by indicating to me that you would rather do so at a meeting with me. If you choose to attend a meeting, you may of course be accompanied by someone to support you if you wish. You might also note that any reply or meeting records may be subject to Freedom of Information.

In either event, I would be grateful for an indication as to whether you wish to make such amendments within the next two weeks. Part of the purpose of engaging in this exercise (which is also being carried out in respect of most other persons who were met with by Review Team) is to avoid any unnecessary interviews between myself and those who may have been involved on the occasion in question where their account is clear and where no further issues arise. It may come, of course, to be the case in respect of some persons that I will, in the course of my investigation, have further information to seek and/or further questions to ask. However I do not intend doing so unless I consider it necessary for the proper conclusion of my investigation.

Finally, I might add that I hope, over the next few days, to be able to circulate what seems to me, on the basis of the materials which I have received to date, to be an accurate chronological account of the relevant events. When you receive a copy of that chronological account I would ask you to consider it and indicate whether, in so far as it relates to matters within your knowledge, it represents an accurate and complete account. As you might understand, clarifying the precise sequence of events is an important first step in my investigation and I wish to do so in early course without unnecessarily asking for individuals to agree to be interviewed by me.

Yours sincerely,

____

Frank Clarke

APPENDIX 4

Winter Escalation Framework Version 6, 24th May 2022

UL Hospitals Winter Escalation Framework Version 6, Date: 24th May 2022

Trigger for escalation is any relevant point in stage B onwards

Stage	Cubicle/Beds	A	B	C	D	E
Core principles of each level		Current services in ULHs	Reduce scheduled care medical/surgical starting with OPD. Directorate dependent.	Maintain time critical scheduled care & cancer service inpatient / OPD. Cancel non-cancer OPD.	Maintain critical cancer care inpatients. Cancel all OPD activity exception RACs, definite tumours & new melanomas	Cancel ALL scheduled care (except what is outlined in the columns below)
ED	49 cubicles Zone A non Covid pathway Zones B-C (12 cubicles) Covid pathway CDU- 12 Cubicles	Up to 23 admitted patients/trolleys (13 cubicles and 10 on corridor occupied by inpatients→ Placement of trolleys in chronological order on wards.	Corridor >23 admitted patients /trolleys* decompress hospital or escalate to Stage C within 24 hours. ** NB Trigger Process Flow Plan (Tina's Plan) for opening of surge and use of ward trolleys UHL	Establish any delays in ED Transfers awaiting AMBU, Specialist review, ED assessment) Flexible Use of Optimend beds	As per C	As per C
AMAU	Non Covid Pathway 19 bays	19 bays in use but can continue to accept ED referral to ensure flow→	18 admitted /24 in department			
JENS	Surge Capacity in SJH **0**, **Nenagh: max 28** (2 day room medical beds & 2 corridor beds, 10 SDW/10 Endo/4 in Old MAU), **Ennis: max 16** (2 Burren, 2 Fergus, 12 SDW), **Croom: 0** surge capacity. **Total surge capacity JENS 44** Staffing redeployment from all sites as required during escalation when in escalation D & E (and depending on resources used in site surge areas). As long as the surge areas can be staffed as a priority, OPD and planned procedures can go ahead but will need daily review as per Executive Operational Team, Meeting. Optimising patient flow and patient transfers across UL Hospitals Group – Red to Green ****– This should only occur where there is clear redeployment and provides solutions to the escalation process.					
Surgical ED/SAU	Non-CVD 16 assessment bays	16 assessment bays in use but can continue to accept ED referrals to ensure flow →	24 admitted patients & 24 patients in the department →	16 admitted pts / Time out called 30min, on call sub specialties / general surgery RV immediately, activated by CD/ACD Peri op		
ICU Capacity	Floor 1: 12 ICU beds Floor 2: 16 HDU Floor 3: 16 Cardiology beds	Beds available	When ICU at capacity 12 beds with inability to decompress→	2 Floors 12 ICU +16/HDU = 28 on level 2 16 HDU Beds flex between ICU/HDU-staffing implications staff redeployment e.g. from POCU and ex ICU staff across the ULHG→	3 Floors 12 ICU +16/HDU = 28 on level 2 16 HDU Beds flex between ICU/HDU-staffing implications 3rd Floor 16 Cardiology beds now becomes HDU and 4th Floor remains with Cardiology *staffing redeployment from all sites	Same as Stage D
Covid-19 Pathway	-7A (7 beds)(more well Covid patients) -8D (20 beds) (All NIV C+ and suspect have to go to 8D)	-7A (7 beds)(more well Covid patients) -8D (20 beds) (All NIV C+ and suspect have to go to 8D)	Maintain and monitor flow in 7A and 8D and prepare to move to next phase C →	When we reach capacity in 7A & 8D next step is 8B becoming a Covid Unit (20 beds). 4B (13 beds) will revert to Peri_Op for the management of the scheduled care pathway along with POCU. Total 47 Covid pathway beds. In the event of an outbreak on another unit the Covid outbreak ward may be considered as a Covid cohort unit to give additional Covid capacity as required. →	CF becomes the next Covid pathway wards (9 Beds). An emergency single room with ante-room facilities for CF patients will have to be protected for CF patients in Ward 3B. This would give a total of 56 Covid pathway beds. Note there would be additional staffing required if this is the preferred option, as CF is staffed for 5 beds.	Pending the Option taken in Step D: If CF is the preferred choice in D _ then the next step in E is converting POCU to a Covid pathway ward (7 beds) with additional staffing required. All scheduled care is cancelled at this point.
Paediatrics	52 beds including Paediatric HDU	Current service	Current service →	Trigger escalation plans (policy date) Maintain service and establish any delays in triage, or seen by decision maker or admission to ward or discharge	As per C	As per C
Diagnostics		Current service	Current service →	Trigger escalation plans (21/10/2020) → OPD work cancelled with the exception of Breast Radiology	Inpatients only OPD work cancelled with the exception of Breast Radiology	Inpatients only OPD work cancelled with the exception of Breast Radiology

Stage	Cubicle/Beds	A	B	C	D	E
				Time critical and urgent appointments continue for allied health In-patient demand triggers for CT/MRI and ultrasound – email to follow from Gena on this matter Out-patient work to continue for radiology in respect of cancers and time critical patients.	Time critical and urgent appointments continue for allied health In-patient demand triggers for CT/MRI and ultrasound – email to follow from Gena on this matter Out-patient work to continue for radiology in respect of cancers and time critical patients.	Time critical and urgent appointments continue for allied health In-patient demand triggers for CT/MRI and ultrasound – email to follow from Gena on this matter Out-patient work to continue for radiology in respect of cancers and time critical patients.
Medicine			Once we need to move to C,D or E the following applies: → Weekend discharges (during times of escalation) Plan to ask Post call Consultant/Reg to dial into huddle for 5 minutes at weekend to identify who is suitable for transfer. Medicine to explore the feasibility of two Consultants on call on Friday and to divide the post take between them on Saturday.	**Bronchoscopy** unit will prioritise inpatient & OPD work **Sleep studies** in inpatient beds will be stood down. **PFT Lab** will prioritise all inpatient work and OPD as capacity allows. **EEG Department** will prioritise all inpatient work and out-patients as capacity allows. **Dermatology** to continue OPD (dependent on in-patient consults been seen in a timely fashion) **Clinical Age:** Nurse led to continue to facilitate discharge and admission avoidance **RAMU** to continue to facilitate discharge and admission avoidance	**Bronchoscopy** unit will prioritise inpatient & OPD work **Sleep studies** in inpatient beds will be stood down. **PFT Lab** will prioritise all inpatient work and OPD as capacity allows. **EEG Department** will prioritise all inpatient work and out-patients as capacity allows. **Dermatology** to continue OPD (dependent on in-patient consults been seen in a timely fashion) **Clinical Age:** Nurse led to continue to facilitate discharge and admission avoidance **RAMU** to continue to facilitate discharge and admission avoidance	**Bronchoscopy** unit will prioritise inpatient & OPD work **Sleep studies** in inpatient beds will be stood down. **PFT Lab** will prioritise all inpatient work and OPD as capacity allows. **EEG Department** will prioritise all inpatient work and out-patients as capacity allows. **Dermatology** to continue OPD (dependent on in-patient consults been seen in a timely fashion) **Clinical Age:** Nurse led to continue to facilitate discharge and admission avoidance **RAMU** to continue to facilitate discharge and admission avoidance DMT request the Escalation Plan remain as is – This will allow for inpatients to be prioritised and if capacity allows the following services to continue: Endoscopy, Bronchoscopy, Cardiology Day Cases, EEG, Dermatology, CAAU, RAMU
Cancer				**Cancer Service to continue**	Cancer Services to continue	Cancer Services to continue
Cardiology		Current service	Current service →	Review scheduled care for day cases. During surge, inpatients are to be prioritised. Scheduled care can continue once Consultants have honoured their inpatient commitments. If this is not possible, scheduled care will have to be cancelled/ curtailed. Speciality consult services must also be prioritised. The Cath Lab will prioritise all inpatient work. Cardiac Diagnostics will prioritise all inpatient work to support early discharge. Inpatients ANP Heart Failure and Cardiac rehab to continue on all sites Daycase Angiography to continue once in-patient demand is met 2x Elective Overnight adm Mon-Fri →once they can be accommodated within cardiology Cardiac diagnostics to continue. Cardiology should be curtailed only when there is a significant build-up of in patients awaiting procedures.	Review scheduled care for day cases. During surge, inpatients are to be prioritised. Scheduled care can continue once Consultants have honoured their inpatient commitments. If this is not possible, scheduled care will have to be cancelled/ curtailed. Speciality consult services must also be prioritised. The Cath Lab will prioritise all inpatient work. Cardiac Diagnostics will prioritise all inpatient work to support early discharge. Inpatients ANP Heart Failure and Cardiac rehab to continue on all sites Daycase Angiography to continue once in-patient demand is met 2x Elective Overnight adm Mon-Fri →once they can be accommodated within cardiology Cardiac diagnostics to continue. Cardiology should be curtailed only when there is a	Review scheduled care for day cases. During surge, inpatients are to be prioritised. Scheduled care can continue once Consultants have honoured their inpatient commitments. If this is not possible, scheduled care will have to be cancelled/ curtailed. Speciality consult services must also be prioritised. The Cath Lab will prioritise all inpatient work. Cardiac Diagnostics will prioritise all inpatient work to support early discharge. Inpatients ANP Heart Failure and Cardiac rehab to continue on all sites Daycase Angiography to continue once in-patient demand is met 2x Elective Overnight adm Mon-Fri →once they can be accommodated within cardiology Cardiac diagnostics to continue. Cardiology should be curtailed only when there is a significant build-up of in patients awaiting procedures.

Stage	Cubicle/Beds	A	B	C	D	E
					significant build-up of in patients awaiting procedures.	
Surgery		Current service →	Current service with daily review →	Consider redeployment from JENs to CCB *** Cancer- time critical & emergency trauma including Croom(21/10/2020)	Elective cancer only, emergency & trauma 4B for time critical	Emergency & trauma lists Elective Theatre beds protected, to continue with Time Critical and Cancers. Protected beds: ▪ 21 Beds [4B(14), POCU(7)] POCU must remain sacrosanct at all-times regarding being protect as Peri Op elective beds. ▪ Eye Theatre- Intravitreal injections to continue ▪ Vascular lab continue as normal ▪ JEN electives continue unless clear plan for redeployment to support escalation
Endoscopy				Focused Meeting: - Scope Inpatients - Consider how Model 2 Hospitals can assist endoscopy flow during escalation	Focused Meeting: - Scope Inpatients Consider how Model 2 Hospitals can assist endoscopy flow during escalation	Focused Meeting: - Scope Inpatients Consider how Model 2 Hospitals can assist endoscopy flow during escalation Continue endoscopy in UHL prioritising all inpatients and permit limited OPD. JEN's OPD should only be cancelled where the sites can demonstrate there is a real benefit in redeployment i.e. Opening surge in their sites or redeployment to UHL to support the escalation.
Elective Medical		Current service →	Current service with daily review →	Newly diagnosed ca. bronch's RALC & time critical angio's (21/10/2020) →	Continue with RALC definite tumours only →	No electives
OPD		Current service →	Review based on rationale for escalation →	Rapid Access Lung Prostate and Breast continue. Review based on rationale for escalation. Consider additional virtual clinics. CAAU, RAMU, Nurse Led Clinics/ANP Clinics (see Appendix 1 below for listing) Review Paediatric clinics and continue without nursing where possible	Rapid Access Lung Prostate and Breast continue Continue the following services: Melanoma/Dermatology Trux. Bx & RA Prostate. Virtual & urgent F2F clinics Rapid Access Prostate & Breast → **CAAU,RAMU, Nurse Led Clinics/ANP Clinics (see Appendix 1 for listing) →** **As per C**	Rapid Access Lung Prostate and Breast continue Virtual & urgent F2F clinics **CAAU, RAMU, Nurse Led Clinics/ANP Clinics (see Appendix 1 for listing)** Peri-Op: Surgeons as a general rule do not generally have large numbers of patients so OPD would only be cancelled for consultants who have >15 patients and cannot demonstrate that they have not rounded. **As per C**

*1m apart social distancing (minimum IPC social distancing requirements & within fire regulations) ** Note expected increase in Respiratory cases will see more patients in ED in coming weeks ***Consider redeployment from JENs in line with redeployment policy 21/04/2020 ****Impact on bed flow & staffing would need consideration from EMT

Escalation is dependent on three main factors: ICU capacity, the number of COVID+ cases and the number of available beds & lack of isolation facilities for COVID-19+/suspect cases in acute and non- acute setting or IPC outbreaks/risks.
At every level escalation to be triggered by the CCD,CD Medicine, CD Peri-op & ATICs, Micro & ID Consultants & CDONM. CCD to inform CEO & COO & Director of Communications of escalation.

Appendix 1 CAAU, RAMU, Nurse Led Clinics/ANP Clinics

CAAU	RAMU	OPD
Blood pressure	DVT, Diabetes, Epilepsy	All Nurse led and ANP Clinic's to proceed
Syncope	Anti Coag, Warfarin Clinic	
Falls Unit	Respiratory , Fibro scan	
Dexa Unit	Aging 7 Therapeutics	

APPENDIX 5

Extract from Medical Records

APPENDIX 6

Sepsis identification under Manchester Triage System

Emergency Triage 3rd edition

Manchester Triage Group

Kevin Mackway-Jones, Professor of Emergency Medicine, Manchester Royal Infirmary, Manchester, UK
Janet Marsden, Professor of Ophthalmology and Emergency Care, Manchester Metropolitan University, Manchester, UK
Jill Windle, Lecturer Practitioner in Emergency Nursing, Salford Royal Hospital, Salford, UK

The Manchester Triage System (MTS), the most widely used emergency medical triage system in the UK and Europe, is employed to prioritise the treatment of tens of millions of patients each year. MTS utilises an easy-to-understand and safe, risk-based system of prioritisation.

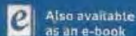
Emergency Triage contains all the information necessary for an MTS user: as such, it is an essential text for all emergency department staff, in particular triage nurses. The book is both a training tool and a reference for daily use.

- Well-organized and well-written
- Updated evidence-based concepts of triage for modern emergency departments
- New charts for abuse and neglect in childhood, unwell newborn, unwell baby
- A new approach to fever in childhood
- An introduction to telephone triage and advice

This book is a must-have tool for all practitioners working in emergency and urgent care.

Titles of related interest:
Paediatric Emergency Triage 9781118299012
Telephone Triage and Advice 9781118369388

www.wiley.com/wiley-blackwell



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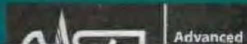
Emergency Triage THIRD EDITION Manchester Triage Group W

Emergency Triage

THIRD EDITION

Manchester Triage Group



CHAPTER 1

Introduction

Background

Triage is a system of clinical risk management employed in Emergency Departments worldwide to manage patient flow safely when clinical need exceeds capacity. Systems are intended to ensure care is defined according to patient need and in a timely manner. Early Emergency Department triage was intuitive, rather than methodological, and was therefore neither reproducible between practitioners nor auditable.

The Manchester Triage Group was first set up in November 1994 with the aim of establishing consensus among senior emergency nurses and emergency physicians about triage standards. It soon became apparent that the Group's aims could be set out under five headings.

- Development of the common nomenclature
- Development of common definitions
- Development of a robust triage methodology
- Development of a training package
- Development of an audit guide for triage

Nomenclature and definitions

A review of the triage nomenclature and definitions that were in use at the time revealed considerable differences. A representative sample of these is summarised in Table 1.1, where the priority categories are shown on the left and the maximum respective times (in minutes) to first contact by a treating clinincan are listed in the right-hand columns.

Emergency Triage: Manchester Triage Group, Third Edition.
Edited by Kevin Mackway-Jones, Janet Marsden and Jill Windle.
© 2014 John Wiley & Sons, Ltd. Published 2014 by John Wiley & Sons, Ltd.

Table 1.1

Hospital 1		Hospital 2		Hospital 3		Hospital 4	
Red	0	A	0	Immediate	0	1	0
Amber	<15	B	<10	Urgent	5–10	2	<10
		C	<60	Semi-urgent	30–60		
Green	<120	D	<120				
Blue	<240	E	–	Delay acceptable	–	3	–
		FGHI					

Despite this enormous variation, it was also apparent that there were a number of common themes running through the timings of these different triage systems, and these are highlighted in Table 1.2.

Table 1.2

Priority	Max. time (minutes)			
1	0	0	0	0
2	<15	<10	5–10	<10
3		<60	30–60	
4	120	<120		
5	<240	–	–	–

Once the common themes of triage had been highlighted, it became possible to quickly agree on a new common nomenclature and definition system. Each of the new categories was given a number, a colour and a name and was defined in terms of ideal maximum time to first contact with the treating clinician. At meetings between representatives of Emergency Nursing and Emergency Medicine nationally, this work informed the derivation of the United Kingdom triage scale shown in Table 1.3.

Table 1.3

Number	Name	Colour	Max. time (minutes)
1	Immediate	Red	0
2	Very urgent	Orange	10
3	Urgent	Yellow	60
4	Standard	Green	120
5	Non-urgent	Blue	240

As practice has developed over the past 20 years, five-part triage scales have been established around the world. The target times themselves are locally set, being influenced by politics as much as by medicine, particularly at lower priorities, but the concept of varying clinical priority remains current.

Triage methodology

In general terms a triage method can try and provide the practitioner with the diagnosis, with the disposal or with a clinical priority. The Triage Group quickly decided that the triage methodology should be designed to allocate a clinical priority. This decision was based on three major tenets. First, the aim of the triage encounter in an Emergency Department is to aid both clinical management of the individual patient and departmental management; this is best achieved by accurate allocation of a clinical priority. Second, the length of the triage encounter is such that any attempts to accurately diagnose a patient are doomed to fail, as this activity requires a consultation rather than a triage assessment. Finally, it is apparent that diagnosis is not accurately linked to clinical priority, the latter reflects a number of aspects of the particular patient's presentation as well as the diagnosis; for example, patients with a final diagnosis of ankle sprain may present with severe, moderate or no pain, and their clinical priority must reflect this.

In outline, the triage method put forward in this book requires practitioners to select from a range of presentations, and then to seek a limited number of signs and symptoms at each level of clinical priority. The signs and symptoms that discriminate between the clinical priorities are termed *discriminators* and they are set out in the form of flow charts for each presentation – the *presentational flow charts*. Discriminators that indicate higher levels of priority are sought first, and to a large degree patients who are allocated to the standard / 4 / green clinical priority are selected by default.

The decision-making process is discussed in chapter 2, and the triage method itself is explained in detail in chapter 3.

Priority and management

It is easy to become confused between the clinical priority and the clinical management of a patient. The former requires that enough information is gathered to enable the patient to be placed into one of the five defined categories as discussed above. The latter may well require a much deeper

understanding of the patient's needs, and may be affected by a large number of extraneous factors, such as the time of day, the state of the staffing and the number of beds available. Furthermore, the availability of services for particular patients will fundamentally affect individual patient flow. Separately staffed 'streams' of care for particular patient groups will run at different rates. This does not affect underlying clinical priority which affects the order of care within, rather than between, streams in such a system. These issues are discussed in more detail in chapter 5.

Training for triage

This book, in conjunction with the accompanying Manchester Triage Provider Course, attempts to provide the training necessary to allow introduction of a standard triage method. This process has been highly successful, not only in the UK where the system originated, but across many countries that sought a standard for triage in their health care systems. It is not envisaged that reading the book and attending a course can produce instant expertise in triage. Rather, this process will introduce the method and allow practitioners to develop competence at using the material available as a first step towards competence in using the system. It must be followed up by audit of individual triage practitioners and evaluation of their use of the system.

Triage audit

The Triage Group spent considerable time trying to pin down 'sentinel diagnoses' – that is diagnoses that could be identified retrospectively and which could be used as markers of accurate triage. For the reasons outlined above, it soon became apparent that even retrospective diagnosis could not accurately predict actual clinical priority at presentation.

Successful introduction of a robust audit method is essential to the future of any standard methodology, since reproducibility between individual practitioners and departments must be shown to exist. This is discussed in more detail in chapter 6.

Beyond triage in the Emergency Department

The concept of triage (determining clinical need as a method of managing clinical risk) and the process outlined in this book (presentational

recognition followed by reductive discriminator seeking) is applicable in other settings. In some of these, for example medical, surgical or paediatric assessment units, the system can be implemented in exactly the same way as it is in the Emergency Department. In other settings, for instance Primary Care or Out of Hours Units, many contacts may be made by telephone. A modification of the Manchester Triage System (MTS) can be used and this is outlined in chapter 7.

The information gained during the triage process can also be used in other ways to improve patient care. It is important, for instance, that clinicians recognise any change in the patients' status as early as possible. Early Warning Scores have been applied in many settings to formalise this function. In the Emergency Department the ABCDE discriminators from the MTS can be used in exactly this way, and the monitoring of physiological parameters, as outlined in chapter 8, is an intuitive way for triage practitioners to put into practice the original exhortation for dynamic triage and that 'every intervention is a triage intervention'.

Finally, many users of the MTS have recognised that the outcome of the presentation selection–priority assignment process is to place individual patients into one of 265 slots in a 53 × 5 presentation–priority matrix. This 'pigeon-holing' can be used to drive pathways of care in systems that have taken to 'streaming'. Particular presentation–priority combinations (e.g. wounds–green, chest pain–orange) may be appropriate to particular streams (minor injuries and resuscitation, respectively, in the examples given). This concept is discussed in more detail in chapter 8.

Summary

Triage is a fundamental part of clinical risk management in all departments when clinical load exceeds clinical availability. Emergency triage promulgates a system that delivers a teachable, auditable method of assigning clinical priority in emergency settings. It is not designed to judge whether patients are appropriately in the emergency setting, but to ensure that those who need care receive it appropriately quickly. MTS has been shown to have functions beyond the initial concept when used to monitor care and to signpost streams of care determined by local provision and actual availability.

APPENDIX 7

The Hospital Escalation Protocol 2020

The Hospital Escalation Protocol 2020 includes:

20+ in ED plus - Max 6 in isolation

- Trolleys on wards
- Flow of trolleys to inpatient wards to a max of 21.
- To place surgical patients on surgical wards and medical patients on medical wards as far as possible.
- CNM1 in admissions to ring CNM2 in ED when beds turn green to be moved within 1 hour of going green. (CNM 2 ED).
- AMU cap at 8.

47 + (20 in ED +MAX 6 isolation + 21 extra trolleys)

- AMU to go to a cap of 10 with medical short stay patients admitted to inpatient beds.
- CDU to take 1 inpatient.

50+ (20 in ED+ max 6 isolation, 21 trolleys on wards, +2 in AMU, CDU-1)

- AMU to go to 14 with medical short stay patients.
- SDW to open to a cap of 8. (Bed management & OpADON). SDW list to be revi and decision made Peri Op Direct/Ops Team.
- CDU - 2 inpatients (Bed management & OpADON)
- Sleep studies cancelled and CFU increased to 8 inpatients

APPENDIX 8

Protocol provided by [Senior Staff Member A]

SURGE CAPACITY/TROLLEY EXCLUSION AND INCLUSION CRITERIA FOR ADMISSION

Inclusion criteria for admission:

- Patients deemed clinically stable by primary team and EWS of less than 6.
- Patients who have clear clinical plans re discharge.
- Patients who are planned discharge the following morning or 48 hrs.

Exclusion criteria for admission:

- Patients who are confused and who are wandering risk
- Patients who need 1:1 or cohort HCA special
- Patients who have self-harm ideations
- Patients who are admitted post substance abuse
- Patients who are aggressive
- Patients who have complex wounds
- Patients who have grade 3 or grade 4 pressure sores
- Bariatric patients
- Patients who use Bipap/C pap at night
- Transfers from Critical care – ICU, HDU or CCU
- Spinal Patients
- NOF fractures
- Infective stools due to unavailability of Ensuite bathrooms
- Patients with IP&C tags
- Deteriorating patients with high O2 demands
- Patients with Epilepsy
- Falls risk patients
- Full care patients / Immobile / Hoist transfers

APPENDIX 9

UHL trolley numbers 2022 - 2024

UHL TROLLEY NUMBERS 2022 - 2024			
Year	**Sum of Ward Trolleys In Use 8am**	**Sum of ED Trolleys In Use 8am**	**Sum of TimeTotal 8am**
2022	3,859	8,516	12,375
2023	10,621	6,326	16,947
2024	4,171	1,911	6,082

APPENDIX 10

Response from Damien Tansey Solicitors

DAMIEN | TANSEY

Mr Frank Clarke
1st Floor Office
31/32 Catherine Street
Limerick
V94 AY27

Our Ref: MCB/BR/JOH0040001
2453.1

Date: 30th April 2024

Re: X-ray

Dear Mr Clarke

Thank you very much for the detailed information that you submitted to our office last week. Our most sincere apologies for the delay in reverting to you which, as you have referenced in your letter, was due to the Inquest.

We note that you have provided a number of documents in relation to the disputed x-ray.

As we have indicated previously, Aoife was taken in a wheelchair from the room. Her parents are absolutely adamant that they did not advise any [redacted] that Aoife did not feel up to it. They maintain that they had an interaction with a [redacted] who came into the room to take Aoife for the x-ray. They asked if they could go with her, and they were told they weren't needed. They have again advised that this happened before Aoife was reviewed by a doctor.

We note from your enquiries that the hospital is satisfied that they have established a chest x-ray was ordered at 5.53am, arrived at 5.53 and filmed at 7.05 with no evidence of intubation. We are at a loss to understand why the x-ray is not in the bundle of records that we received from the hospital. We note that the [redacted] has advised that Aoife was relatively well and stood up for the chest x-ray. This does not marry with the positions and evidence provided at the Inquest last week which determined that from approximately 2.30am, Aoife wasn't even able to go to the toilet without the assistance of a wheelchair.

You might please confirm that the [redacted] have been interviewed. We would also be obliged if you could please provide us with a copy of the chest x-ray.

Yours sincerely

Sent by email only and accordingly bears no signature.

DAMIEN TANSEY
SOLICITORS LLP

APPENDIX 11

[Nurse C]'s Escalation Report (18/12/22)

17/12/2022						
Escalation Report –	01.00am	06.00am				
Total no. admitted patients	48	50				
Longest waiter (Outside CDU)	103hr	108hrs				
No of Patients Over 75 : Admitted	13					
Non Admitted	20					
No. patients in CDU						
Total no. patients in DEPARTMENT	**168**	**155**				
Triage	7					
Waiting Time to been Seen	53min					
Resus	12	12				
A/W HDU/ICU	0					
Intubated patients	0					
Zone A	72	80				
Waiting Time to been Seen	38(21hrs)					
Zone B+C	45	42				
Waiting Time to been Seen	17(15hrs)					
Paeds	29..	00:00				
Waiting Time to been Seen	19.(10hrs)					
Over 24hrshrs in Dept : Admitted	36					
Non Admitted	0					
No's In Medical Box	6					
Time waiting to be seen	3hrs					
No in Surgical Box	0					
Time waiting to be seen	0					
No a/w maxfax/ENT/gyane	0					
Waiting Time to been seen	0					
Maxims checked v's Bed booking & Updated:	yes					
Staffing numbers-	13+2					
Sick leave :						
Covid leave :						
Nursing shift unfilled :	4					
HCA shift unfilled :	0					
No of Covid +ve admitted						
No of Covid +ve ED pathway						
Longest Waiter in the ED	**21hrs**					
ED Consultant: @	[redacted]					
OpADON : @	[redacted]					
Patient Flow: @	[redacted]					
cnm3	[redacted]					

Overcrowding and inability to adequately socially distance between patients within the zones has been risk assessed separately and esalated to SNM
Overcrowding remains on the ED risk register.

Issues to be highlighted

DEPARTMENT TONIGHT EQUATES TO MAJOR EMERGENCY ,166 PT 48 CURRENTLY ADMITTED , 67 CAT 2 PT AND 39 OVER 75YRS [redacted] CONTACTED AND RISK ESCALTED ALSO [redacted] INFORMED, PATIENT SAFETY AT THE HIGHEST RISK DUE TO STAFFING DEFICITS AND OVERCROWDING AND LEVEL OF ACUITY WITH HIGH AMOUNTS CAT 2 .NURSING STAFF UNABLE TO PROVIDE ADEQUATE MONTIORING OF PATIENTS,OBSERVATIONS OF PATIENTS AND SAFE MEDICATION ADMINISTERING, STAFF HEALTH AND WELLBEING AT RISK DUE TO OVERWHELMING WORK LOAD ,DANGEROUS WORKING ENVOIMENT DUE TO TROLLEYS BACK TO BACK AND EMERGENCY EXITS AND RESUS TROLLEY BLOCKED .RESUS SO UNSAFE WITH 14 PATIENTS ,UNABLE TO PROVIDE SAFE CARE TO THESE ACUTELY UNWELL AND HIGH ACUITY PATIENTS ,CURRENTLY 3 NURSING STAFF LOOKNIG AFTER 14 RESUS PT, 2 STEMI ALREADY TRANSFERED TO CATH LAB .

UNABLE TO PROVIDE SAFE CARE TO PATIENTS DUE TO HIGH NUMBER OF PATIENTS AND NURSING DEFICITS

STAFF EXSPOSED TO CONTSTANT ABUSE FROM PATIENTS AND RELATIVES RE WAITING TIMES AND LACK OF DIGNITY FOR PATIENTS ON TROLLEYS

.STAFF WORKING UNDER SEVERE PRESSURE AND IN UNSAFE WORK ENVOIRMENT DUE TO OVERCROWDING,

STAFF NURSE X 1 SENT FOR NIGHT PLUS 4 STAFF SENT OVER THE NIGHT TO COVER BREAKS , STAFF RECEIVED 1 SHORT BREAK OFF THE FLOOR IN THE 12HRS SHIFT

RESUS NUMBERS AT 12 ALL NIGHT WITH 3 NURSE STAFF

67 CAT 2 PATIENTS IN DEPARTMENT .

40 OVER 75YRS

PAEDS UNDER SEVERE PRESSURES ALL NIGHTS WITH LONG DELAYS PAEDS CONSULTANT CONTACTED ,DID COME INTO TO DEPARTMENTS FOR FEW HOURS,

DELAYS FOR CAT 2 AT 24HRS

THE LEVEL OF RISK TO PATIENTS AND STAFF IN THIS DEPARTMENT OVERNIGHT AT A NEW LEVEL NEVER BEFORE EXPERIENCED

Pregnancy

HCA Special

Pressure areas:

APPENDIX 12

Article provided by Dr Mark Doyle

SAFETY BY DESIGN

Violations and migrations in health care: a framework for understanding and management

R Amalberti, C Vincent, Y Auroy, G de Saint Maurice

Qual Saf Health Care 2006;**15**(Suppl I):i66–i71. doi: 10.1136/qshc.2005.015982

Violations are deliberate deviations from standard procedure. The usual reaction is to attempt to eliminate them and reprimand those concerned. However, the situation is not that simple. Firstly, violations paradoxically may be markers of high levels of safety because they need constraints and defences to exist. They may even become more frequent than errors in ultrasafe systems. Secondly, violations have both positive and negative aspects. On the one hand they occur frequently, increase system performance and individual satisfaction, are mostly limited to practices with limited safety consequences, and therefore are often tolerated or even encouraged by the hierarchy. On the other hand, extreme violations can lead to real danger or actual harm. This paper proposes a three phase model derived from Rasmussen's theory of migration to boundaries to explain the mechanism by which the deviance occurs, stabilizes, regresses, or progresses to harm. The model suggests that violations are unavoidable because system dynamics and deviances are markers of adaptation to this dynamicity. Violations cannot be eliminated but they can be managed. Solutions are specific to each step of the model, with a mix of relaxing constraints, increasing peer control (staff), and constraining dangerous individuals.

See end of article for authors' affiliations

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Accepted 21 July 2006

In 1987 the ferry *Herald of Free Enterprise* left Zeebrugge's inner harbour, took on water, and sank. The immediate cause of this loss was that, to save time, the back ramp had not been fully closed before the ship left harbour.[1] In 1999 an accident occurred at an uranium processing plant operated by JCO in Tokai-Mura, Japan. The workers were anxious to finish their job at the conversion building and decided to use the precipitation tank instead of a buffer column (a much smaller device) to increase their performance when purifying and homogenizing uranium. The concentration of product became critical and the system exploded, causing the most severe nuclear accident since Chernobyl.[2] Both these accidents were caused not by unintended errors but by deliberate deviations from rules and standards. In both cases, accident analysis showed that the workers' deviations from normal operating procedures resulted from a long progressive drift in practice. These deliberate deviations—known as violations—have been an important topic in safety analyses in industry but have been little studied in health care.

Violations are deliberate deviations from standard instructions. However, defining non-compliance is not straightforward. The expected level of compliance—and therefore the interpretation of non-compliance and violation—varies according to the type of instruction, the nature of the work, and the social and organizational context. In some cases strict observance of rules is expected, whereas in other cases a certain degree of flexibility is tolerated or even expected. In health care, for instance, evidence based medicine is seen as a guide to practice, not a mandatory set of intstructions. Serious violations of strict rules are likely to be severely penalised, if discovered, in any environment. This makes the study of violations particularly challenging in that studies are addressing a topic that is both sensitive and partially hidden from the usual lines of enquiry. The difficulty of studying violations partially explains the lack of knowledge and understanding of the topic.

Violations have been the cause of some major healthcare incidents. For instance, five deaths were recorded in Florida after liposuction was given in doctors' offices. The death rate for this procedure was 1 per 5000 in offices compared with 1 per 200 000 in hospital. The primary cause of death in the doctors' offices was that patients were given very high doses of lidocaine that "pushed the envelope" of use of that drug. Following these deaths the state of Florida imposed a 90 day moratorium on all ambulatory surgery to allow further investigation; there were very few regulations covering procedures in doctor's offices and there were clear and frequent violations of the recommended protocol for the use of local anesthesia.[3] However, this last example also shows how difficult it is to define a violation. Although such high doses of lidocaine were clearly unacceptable violations of accepted anesthesia practice, they were nevertheless tolerated if not completely accepted in the professions of dermatology and plastic surgery.

Violations occur frequently in all industries, even those with very good safety records. In aviation, an extensive study of crews' deviations from procedures (noted by trained observers sitting on the jump seat for some 3500 flight segments) showed that "intentional non-compliance" represented 55% of all errors and violations, but only 3% of these affected the flight in any adverse way.[4] In another study Degani and Wiener[5] showed that about half the checklists on airplanes were not correctly completed mainly because of interruptions and

distractions and poor design of check lists. In medicine a total of 67 violations of procedure over 59 operations were noted during a large study of alarm systems in the operating theatre.[6] The most significant event occurred in a private hospital that was close to bankruptcy. One of the anesthesiologists, apparently from a desire to save money for the clinic, decided to reuse the same syringe (of diprivan) for consecutive patients. He loudly justified this deviant behavior to the nurses, telling them that the surgical list in the theatre that morning consisted only of a series of short, rapid, turnover cases. If he were to use a fresh ampoule of diprivan for each patient, "*then there would be a considerable cost associated with this practice, without any safety benefits*". Note that this doctor did not consider the risks of this behavior, justifying it solely on the grounds of economy, and also that the behavior had no immediate consequences for patients. This behavior was apparently accepted by the operating theatre medical staff, nurses, and surgeons. This illustrates the fact that violations may need to be explained both by individual motivation and wider social and organizational processes.

Violations, therefore, are a complex multifaceted phenomenon. They occur frequently and may save time and bring benefits to both individuals and systems. They may be tolerated by the wider clinical team and even actively encouraged if there is pressure to increase workload and throughput of patients. However, extreme violations may put both people and systems at risk. The existence of violations poses a number of problems for health care:

- Are some violations acceptable if they do not lead to danger or harm?
- Are acceptable and unacceptable violations part of the same continuum?
- What are the criteria for tolerance?
- Should they lead to different safety approaches?

This paper addresses these questions by providing a framework for understanding violations and system migration.

ABSENCE OF DATA SHOULD NOT MASK THE IMPORTANCE OF THE PROBLEM

Data on violations are sparse in health care in that they are seldom explicitly assessed. For instance, in the major epidemiological studies of adverse events the term "violation of a protocol or a rule" is explicitly used only in the Quality in Australian Health Care Study of 1999 where "violations: were a cause of 4.8% of adverse events. There are no data on violations in the other national studies of adverse events.[7–10]

Three reasons can be put forward to explain the relative absence of information about violations in health care. Firstly, health care has fewer explicit rules than other high hazard industries. While there are a large number of protocols and guidelines, there is usually sufficient flexibility and room for clinical judgement so it can be difficult to state unequivocally that a violation has occurred. The multiplicity of guidelines and recommendations at both national and local levels means that there can never be strict compliance to any particular set of rules or guidelines: inevitably, national guidelines in particular are never seen as more than recommendations. Secondly, much of the information about safety problems in health care has been derived from incident reporting systems and it is difficult to assess precisely the presence or absence of errors and violations from summary narrative data. Last, but not least, violations are the most difficult unsafe acts to gather in any voluntary reporting system. Reporting violations may lay the individual open to accusations of negligence or professional misconduct even if there was no intention to harm.[11–14] For all these reasons, violations are insufficiently studied in health care, despite the fact that they probably represent a serious source of danger and because they tend to become more frequent than errors as systems become safer.[14]

PERSPECTIVES ON VIOLATIONS

Violations can be understood from a number of different perspectives, which vary in the nature of the explanation advanced and the discipline from which they are derived. We briefly outline some of the principal theories and then discuss an overall framework which endeavors to integrate the cardinal elements of these various perspectives.

Motivation and attitude

The first category of theory emphasises the local and contextual motivation of individuals as the main source of the violation. The best example of this category is the theory of planned behavior,[15] where the likelihood of violation is determined by the individual's assessment of the consequences, the social influences on them, beliefs about control, and personal moral codes and beliefs. This theory was used, for example, to measure the attitudes and intentions of drivers to commit violations such as drunk driving, speeding, close following, and dangerous overtaking.[16] The theory relates the occurrence of violations to individuals' willingness to break rules, the likelihood of detection and of consequences.

Organizational and cultural approaches

The second category of theories points to organizational and cultural factors as the principal causes of violations. We can distinguish two broad theoretical frameworks in this category.

The first framework relates both to the "vulnerable system syndrome" (VSS) proposed by Reason *et al*[17] and Tucker and Edmonson's concept of first and second order problem solving.[18] Reason *et al* proposed that a cluster of organizational pathologies—the VSS—renders some systems more liable to errors and violations and, because of this, to accidents and adverse events. VSS has three interacting and self-perpetuating elements: blaming frontline workers, denying the existence of systemic error provoking weaknesses, and the blinkered pursuit of productivity and financial indicators. Such organizations fail to learn and so perpetuate problems. This parallels Tucker and Edmondson's description of hospital workers responding to problems with a quick fix—the immediate problem is solved but the underlying problems are ignored and allowed to continue.[18]

A second well known framework, proposed by Diane Vaughan, also considers violations as a result of a pathological culture but highlights the role of social routines that progressively mask the problem. Vaughan considers that violations set in gradually over time, with operators becoming gradually more lax in their performance. This "normalisation of deviance" is maintained by structural secrecy, the absence of incidents, and the tolerance and absence of reaction of senior management. The best example of this approach is probably the Challenger space shuttle explosion.[20]

Adaptation and flexibility

The third category of theories was developed within the Russian and French occupational psychology tradition of adaptation. They consider violations as a necessary adaptation of professionals in coping with the conflicting demands of complex work situations.[21 22] From this perspective, violations are not a hazard; rather, they reflect the intelligence and flexibility of frontline workers. Extensive studies, mostly reported in French, have been devoted to understanding the adaptation of procedures by workers to deal with the demands of the work. The catachreses (creation

of new usage for a tool) have been specifically studied within this framework. Solutions to the problems of violations rely less on asking workers to increase their adherence to procedures than on changing the design of the work to tolerate greater flexibility of practice.

Another well known contribution in this same field of adaptation is the law of requisite variety expressed by Ashby in 1956.[25] This law considers that a large procedural variation is the only guarantee of an effective learning process and should not be assimilated to error.

All of these approaches on adaptation have largely inspired the basis of the high reliability organization's theoretical framework and the need for organizational learning in health care.[26 27]

The theories outlined in this section address different aspects of the same problem from different perspectives at different stages of the evolution of the social system. Some address individual motivation while others address organizational and cultural influences. Most tend to suggest that violations are behaviors that need to be eradicated in the pursuit of safety, although it is clear that violations are often unavoidable even if not desirable.

A GENERAL FRAMEWORK FOR UNDERSTANDING THE POTENTIAL FOR VIOLATIONS

The final theory to be described derives originally from Rasmussen's framework model of system migration[28] which has been subsequently extended by Amalberti.[29] The Rasmussen/Amalberti framework attempts to integrate the various perspectives on violations and to resolve some of the apparent contradictions between them. Rasmussen emphasised that front line workers do not follow procedures in a strict and logical manner, but try to follow the path that seems most useful and productive at the time. Workers operate within an envelope of possible actions which is influenced all the time by wider organizational and social forces. Rasmussen also described the pressures on individuals and systems to move towards the boundaries of safe operation, as workers are constantly having to adapt and react to pressures for increased performance and productivity which erode the margins of safety. Furthermore, these violations can become more frequent and more severe over time so that the whole system "migrates" to the boundaries of safety until an accident or recalibration occurs which forces a realignment. These external pressures, coupled with individual rewards and benefits, may over time modify the work being carried out, lead to rules and recommendations being progressively ignored, and eventually greatly increase the possibility of disaster as the organization becomes accustomed to operating at the margins of safety.

Amalberti has extended Rasmussen's model to study violations in aviation,[29] train drivers, and rotary press.[30] In particular, Amalberti has drawn attention to the time course of system development and the manner in which a system migrates to the boundaries of safety. Three phases in this process can be distinguished:

- Initial safe space of action.
- Creation of borderline tolerated conditions of use (BTCUs).
- Normalization of deviance and reckless individuals.

Initial safe space of action

The first phase corresponds to the initial design of the work process. At that stage the process is, ideally, designed to operate according to a set of rules and procedures with some regard for the likely pressures of production. In production line or automated systems, many constraints and failsafe procedures will be introduced to act as defences against error and violation and constrain the limits of human action (fig 1). In health care, processes often evolve rather than being

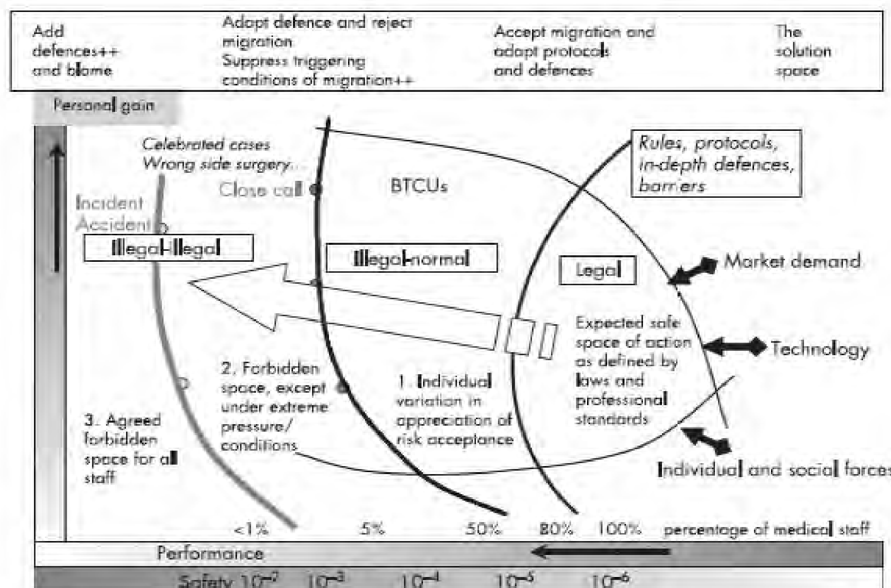

Figure 1 Reference model of migration and transgression of practices proposed by Amalberti.[29] The initial safe space of action, as defined at the design stage, is usually much narrower than the range of operation in actual practice. External pressures on performance, from the organization or from individuals, make migration of the system almost unavoidable. Normally, migration is limited to borderline tolerated conditions of use (BTCUs) in which staff tacitly accept routine minor violations. However, some individuals commit more extreme violations, either because of personal characteristics or because of exceptional circumstances, whether real or imagined. The behavior of these people may encourage further extreme violations in other staff.

designed and constraints may not be strong, but there will at least be an informal understanding of the proper procedures.

Creation of borderline tolerated conditions of use

The second phase occurs when the process commences operation and must continuously adapt to new social and technical demands. The system migrates towards the boundaries of safe operation through the combination of pressure for greater performance (horizontal axis) and the secondary advantages for the individual (vertical axis). Barriers are quickly bypassed under the pressures of real life. Senior management are frequently under pressure to increase output and constrain the use of resources (do the same amount of work with less staff, with equipment missing or out of order, etc). These demands transmit at the front line to a pressure to act more quickly and, ultimately, to violate basic procedures. Once this has occurred there may be a second migration in the sense of a further move towards unsafe practice. Individuals who have been pressured to cut corners in order to increase performance come to think that they are "officially" transgressing established rules and that their behavior has in some way been sanctioned. The result is that the system migrates towards a "normal illegal" area of stabilised operation.

At the "normal-illegal" stage, violations are better termed "borderline tolerated conditions of use" (BTCUs)[30] and may be viewed as providing management and individuals with the maximum benefit for the minimum and accepted probability of harm. These BTCUs have four features: (1) they are first seen as benefits and not as risks; (2) they enhance performance of the system or provide advantage for the individual; (3) they are tolerated by senior management and sometimes even required by it; and (4) they are associated with a variety of informal safety measures. Safety behavior, which may or may not be effective, is now operating within a social context quite independent of the rules and procedures envisaged by the designers of the system.

Normalization of deviance and reckless individuals

The third and last phase occurs after a certain amount of time has passed. The same violations may be committed as in the second phase, but these are now routine and so common as to be almost invisible to both workers and managers, echoing the normalization of deviance noted by Diane Vaughan.[30] At this stage, any further deviance may easily result in patient harm and is generally counted as negligent or reckless conduct. A limited number of individuals, in the absence of a tight social control, are willing to violate basic procedures to the point of recklessness and actual patient harm. Moreover, these individuals are not only a danger to themselves but they may also influence the "other" workers if no action is taken to control them.

CONSEQUENCES OF THE MIGRATIONS MODEL FOR SAFETY MANAGEMENT

The arguments set out above suggest that violations pose considerable challenges for the management of safety. In most settings they are numerous, and yet comparatively few lead to harm or real danger. They are therefore tolerated and even viewed as normal occurrences in routine work. Furthermore, they are influenced by a range of personal, social and organizational factors and their occurrence may also have a distinct time course as a system migrates to the boundaries of safety or recalibrates following an adverse incident. As yet, violations are incompletely understood and the research base remains extremely slender. However, even with this limited knowledge, there are some important and immediate practical implications.

Incident reporting systems do not detect violations and migrations

Reporting systems are poor at reflecting the nature and frequency of violations, particularly when these take the form of BTCUs—that is, violations that have become routine and tolerated. As these events have become normal, they are not regarded as unusual and it is difficult to act decisively even when they are detected. Ineffective memos may be circulated reminding workers of the (old) rule, but the impact of these is short lived since the new behavior has already become socially sanctioned.

Detecting violations and system migration requires attention to progressive drift in practices (proactive control) rather than reacting to incidents (reactive control)

While it is difficult to provide definitive data on violations, except in a specially designed study, the issue can nevertheless be addressed in meetings between staff. Just as violations are in part a socially determined phenomenon, relying on complicit acceptance by the group so they can be reduced by a mutual decision that such behavior will no longer be tolerated. Such discussions can take place in a meeting of clinical staff, provided the culture is open enough to allow such conversations to take place. For such a discussion to be productive it is vital that senior clinical staff (and, ideally, managers) are also involved, both to understand the problem of BTCUs and to discuss the acceptability and elasticity of "rule interpretation".

Violations cannot be eliminated but they can be managed. This may require adapting existing rules. A system lives and changes and these transformations must be accepted. The case reported in box 1 is enlightening because it shows that it is counterproductive to try and set up impenetrable barriers against violations. When thinking about safety we tend to think of an ideal world of clear rules and procedures, but actually these defences can be extremely fragile. The rules and procedures give a sense of reassurance, but we seldom test them in a different context such as during weekends or with low qualified staff. We need first to understand the pattern of violations and system migration, while gradually changing the behavior of the staff within these systems. In

Box 1 The difficulty of eliminating violations

In a Paris hospital in 1997 a patient died in the ICU because an alarm failed on a monitoring device. After investigation this machine proved to be new and met all European standards. These new standards, contrary to the previous French standard, allowed all alarms to be turned off; the previous French equipment standard meant that at least one alarm was always on. Once the risk was identified, the general manager chose to contain and neutralize the risk by deciding that the procurement policy would allow only the purchase of equipment that conformed to the older French standard.

However, a second death occurred for the same reason in 2000. After investigation the general manager noted two violations of the procurement policy. Firstly, a significant number of machines in operation in France had been returned to European standards after maintenance operations carried out by the manufacturer. In these cases the local maintenance department had often not been informed, as was the case for the machine blamed for the second death. Secondly, in spite of the procurement policy, some machines had been bought which complied with European standards and allowed all alarms to be turned off.

other words, it is better to manage risk than to try to eliminate it artificially because history shows that, sooner or later, defences will be overturned.

Controlling violations and system migration by limiting the triggering conditions

Several factors that trigger violations are well known in the literature, the most frequent being the setting of unachievable goals. Whenever a standard is set, some individuals or organizations will decide that the costs of compliance exceed the cost of non-compliance.[31] As standards are made more stringent, the costs of compliance increase steeply while the cost of non-compliance remains more or less constant. Explicit discussion of this issue with those setting targets is necessary to control this. Other triggering factors operate at the level of the clinical team, as staff will sometimes violate a procedure in order to save time or to help other members of the team—for example, inadequate briefing of a new member of staff so that a clinical can proceed more quickly. Such issues must be seen not just as "one-off" instances of no consequence but as a small step in the migration of a system to its safety boundaries.

Identify and control individuals who are more prone to violations

Patient safety has made much of the role of system factors in the occurrence of error and, to a lesser extent, in the occurrence of violations. This is in some ways unfortunate in that it has meant that insufficient attention has been paid to personal factors that may lead to safe or unsafe practice. In all human groups, some individuals are always more prone to deviate than others; in such case, the control of violations largely depends on the wider clinical team. In the absence of this effective peer control, some reckless or overconfident individuals will continue migrating to the boundary of safe practice and even over it. Once that stage has been reached, the only possible way of controlling the system is to report that individual and take appropriate action. In dealing with these individuals, a certain flexibility is required depending on the problem and maturity of those concerned (see Caroll and Rudolph elsewhere in this issue).

CONCLUSION

Human beings never fully comply with rules, and deviation from procedures occurs in all industrial systems. Violations and system migration have been insufficiently studied and it is important to acquire more knowledge about the causes and evolution of violations. New methods will be required to study migration and violations in health care, both for the purposes of research and in order to observe and manage violations in clinical settings. Reporting systems are largely ineffective in monitoring more serious violations, usually only providing information after a violation has caused some harm.

Managing violations is not a trivial matter. Some flexibility with regulations and standards is probably required in complex sociotechnical work to make the system efficient and adaptive to changing circumstances. However, more extreme violations may lead to a dangerous loss of control of both individuals and systems. The balance between the two extreme positions—tolerant versus punitive approaches—is not well understood and requires fine judgment and continuous monitoring in any safety critical setting. In the present state of our knowledge it seems that regular short periods of systematic observation of practice and a continuous dialogue about practice within clinical teams are probably the best methods of managing violations and preventing extreme system migration.

Key messages

- If a system is designed with only a limited sphere of safe operation, violations are very likely to occur under the conditions of actual performance.
- Violations cannot be eliminated but they can be managed. Working conditions, staffing, and medical knowledge always evolve and change over time. Borderline tolerated conditions of use (BTCUs) are best thought of as an understandable—although not necessarily desirable—adaptation to these changes. Simply considering BTCUs as unacceptable behaviors requiring disciplinary action is unhelpful; a better strategy is to monitor performance continually and to identify both violations and system migrations at an early stage.
- Dialogue between clinicians and managers is a key factor in establishing a shared safety culture. Violations and potential system migration must be discussed openly.
- The management of violations must begin at the clinical level, in ongoing discussions between staff on standards of safe practice and acceptable and unacceptable deviations from rules and standards. When it is clear that a violation is in fact adaptive, then procedures may need to be adjusted to reflect this.
- In the absence of effective peer control, some individuals will gradually commit more extreme violations. At that stage the only way of controlling the system is to identify that individual and to take appropriate remedial or disciplinary action.

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APPENDIX 13

PMIU Graphs

Ward Trolleys

Aims

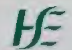
Remove Ward Trolleys

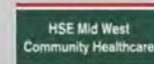
Improve and Protect Streaming Pathways

Improve and Protect Elective Pathways

Reduction Emergency Department Congestion

Improved Patient Experience





Immediate Steps

Improvement is constant

Week 4

Week 3

These Actions set the course for change

Week 2

Week 1

Integration

Over 75s Capacity
Immediate Response Staffing
>14 day process SOP
Flow Education
Roster Redesign

HSE Mid West Community Healthcare

Ospidéil OL UL Hospitals
Working together, caring for you

APPENDIX 14

SOP for the role of Executive on-Call in place in December 2022

Ospidéil OL
UL Hospitals

Policy Title: SOP for Role of the Executive On-Call

Document reference number	1/2017	**Document drafted by**	Claire Hartnett
Revision number		**Document approved by**	Colette Cowan, CEO
Approval date	September 2017	**Responsibility for implementation**	Noreen Spillane, COO Margaret Gleeson, CDONM
Revision Date	September 2018	**Responsibility for evaluation**	Noreen Spillane, COO Margaret Gleeson, CDONM
Number of pages	4	**Responsibility for Revision**	Noreen Spillane, COO Margaret Gleeson, CDONM

Table of contents

1.0 Policy Statement

The role of the Executive-on-call is to advise and provide support to the operational ADON across all the UL Hospital sites out of hours.

2.0 Purpose

The purpose of this standard operating procedure is to outline the function of the Executive On-Call.

3.0 Scope

This procedure applies to all operational management staff.

4.0 Responsibility

It is the responsibility of the Directorates to run the business of the UL Hospital Group during core working hours. Patient Flow and Bed Management is the responsibility of the ODON and the Bed Manager with support from Directorates when required.

5.0 Guideline

The function of the Executive-on-call is as follows;

- To chair the Huddle on a 7 day basis.
- The Operational ADON on duty should ensure that they have exhausted all other options prior to contacting the Exec on call out of hours. This includes considering related hospital policies, procedures and guidelines.
  The types of situations that are likely to require Exec on Call input listed below for guidance:
- Black bed status
- Major Incident/Implementation of Emergency Plan
- Maternal or other unusual death
- Press enquiries – Comms should be advised
- Staff suspension
- Other untoward incidents which are so unusual or serious that Operational ADON feels they should be brought to the attention of the Exec on Call in real time
- Exec on call should be informed of external unannounced audits
- Communication with the Exec-on Call should be through the Operational ADON except in exceptional circumstances. In the event of an emergency situation or unusual event, the Operational ADON on duty may require advice and support from the Exec on Call via phone. Update from the escalation meeting should be communicated to the Exec-on-Call by email from the Bed Manager/Operational DON.
- The Executive-on-Call should be contacted in the event of a Major incident

- Executives on call are required to be contactable at all times during their out of hours' time on call. The Exec on Call will respond to issues raised over the telephone, as is necessary. On occasion e.g., in the event of a major incident they may be required to attend the site.
- The Exec on call reports to the relevant Directorate Manager any extraordinary event if required, they will also make contact with the next Exec-on-call if necessary.

6.0 Implementation Plan

On-call rota implemented.

7.0 Frequency of Review

Review will be every two years or more frequently if indicated.

8.0 Method used to review operation of the Standard Operating Procedure

SOP will be reviewed when required at the Directorate General Managers meeting and the Senior Nurse Managers Professional Council. Changes and updates will be distributed and discussed with all stakeholders to ensure transparency and understanding.

APPENDIX 15

Updated SOP for the role of Executive on-Call

ULHG Senior Manager Support out of normal working hours

Standard Operating Procedure

Version 0.8 March, 2024

Definition of Senior Manager On-Call

A senior manager on-call is rostered by the rota master out of normal work hours from 17:00 – 09:00 Monday to Thursday and from 17:00 Friday to 09:00 Monday (inclusive of Bank Holiday Mondays and designated Public Holidays from 09:00 – 09:00) who can be contacted in order to provide a professional appropriate escalatory advice and support to site rostered management if necessary.

Introduction

1. UL Hospitals Group is committed to ensuring the provision of senior management support to on site management providing services outside of normal working hours (from 17:00 – 09:00 Monday to Thursday and from 17:00 Friday to 09:00 Monday - inclusive of Bank Holiday Mondays and designated Public Holidays – timelines for public holidays from 09:00 – 09:00 the following day).
2. The operation of 24-hour services can sometimes require the support of senior managers for reporting/notification of incidents/notification of SREs/authorisation /Escalation to the Executive team purposes which may be outside the capability or authority of on site management on duty only applies from 17:00 – 09:00 Monday to Thursday and from 17:00 Friday to 09:00 Monday (inclusive of Bank Holiday Mondays and designated Public Holiday from 09:00 – 09:00). To note the Directorate Management teams provide governance from 09:00 – 17:00 from Monday to Friday with the exception of Bank Holidays.
3. EMT has the overall accountability and responsibility for all UL Hospitals (UHL, Ennis, Nenagh, Croom, UMHL)
4. This SOP outlines the arrangements, roles and responsibilities for the Senior Manager on Call, alongside arrangements for duty.
5. This SOP supports and outlines the role of the Senior Manager on Call is to advise and provide support to the on site management team across all UL Hospitals Group hospitals out of hours from 17:00 – 09:00 Monday to Thursday and from 17:00 Friday to 09:00 Monday (inclusive of Bank Holiday Mondays and designated Public Holidays – timelines for public holidays from 09:00 – 09:00 the following day).

Scope

6. This SOP at the discretion of UL Hospitals Group CEO applies to Heads of Service, General Managers and Directors of Nursing who are employed by UL Hospitals Group and undertake operational On-call duties. All staff should be aware of the SOP and the role of the Senior Manager on Call.
7. This SOP does not replace core business hours operational SOPs (during core business hours standard operational Directorate Management structures apply within UL Hospitals Group).

Aim

8. The aim of this SOP is to outline the operational practice of the Senior Manager on Call out of hours and ensuring the operational resilience of the organisation. This SOP outlines UL Hospitals Group escalatory process and expectations of those undertaking the role out of hours (17:00 – 09:00 Monday to Thursday and from 17:00 Friday to 09:00 Monday including public holidays).

Responsibilities

9. All Senior Manager on Call are responsible for:
    a. Participating in the rota and undertaking the duties as outlined in the Senior Manager on Call role.
    b. Chairing of HMT on Saturday, Sunday and Public holidays at 09:00 for the University Hospital Limerick Group.
    c. Communication of any relevant updates following conclusion of HMT or site communication.
    d. Each Senior Manager on Call is responsible for ensuring their own contact details are kept up-to-date, notifying the MAJOR EMERGENCY team and the Switchboard board.
    e. Arranging cover when they are unable to participate in the on-call rota and notifying relevant individuals of changes. The rota master will be responsible for managing On-call rota deficits arising from unscheduled leave and communicate timely once the rota has been updated
    f. Attending any relevant training requested by the COO.

10. All Senior Manager on Call are responsible for ensuring that they have access to the most updated copy of the hospital group escalation plan and the internal ED escalation plan.

Roles

Senior Manager On-Call

11. The Senior Manager on Call duty will run from 17:00-09:00 on weekdays and 17:00 – 09:00 for weekend days (Friday evening through to Monday morning * *Public Holiday's will be covered by the* Senior Manager on Call *from 09:00 – 09:00*). Senior Manager on Call will be on for 1 day up to a maximum of 16 singular days/or 1 week in every 16 week cycle (currently a 13 week cycle) of the rota. Each member of the rota will be expected to undertake a fair share of weekends and public holidays in accordance with the rota distributed by the Rota Master and pending agreement by all Senior Managers On- Call through the INMO, SIPTU, FORSA industrial organisers and the WRC process.

The Senior Manager On-Call is responsible for:
    a. Being a point of escalation for any operational issues that the hospital site management out of hours has not been able to resolve, and for the escalation of operational incidents to EMT.
    b. Utilise critical analysis and decision making skill sets to formulate a plan, which will mitigate any risks presented by operational challenges when reviewing any information escalated to the Senior Manager on Call by the site managers to enhance staff and patient safety.
    c. Manage any business continuity issues with assistance from required speciality specific directorates e.g. infrastructure damage due to fire, infrastructure due to water damage for example.

d. Escalation of a Major Emergency to the EMT representative and ensure that the incident cascade has been activated via switchboard.
e. Escalation of any major incident which either has a significant impact on the organisational perspective, significant risk to patient safety or significant communication, financial or IT implications.
f. Directly managing the organisation's response to an incident until EMT available.
g. Overseeing and supporting, but not be directly involved in the operational response to a major incident.
h. Ensuring a communication handback through the Head of Service at HMT (Monday to Friday with the exception of Public Holidays).

Medical Staffing

12. The Senior Manager on Call is not responsible for medical, nursing, administration or support staffing out of hours. Medical staffing shortfalls out of hours remains under the remit of the relevant On Call Consultant. Nursing and HCA staffing deficits are managed by the site specific OPADON.

On-call rota participants

Senior Manager On-Call

13. The Senior Manager on Call rota at the discretion of the CEO will consist of all:
    - Heads of Service
    - Directors of Nursing
    - General Managers

Escalation, Recording and Reporting

Escalation

14. In the event Senior Manager on Call is unable to resolve an escalated matter then a member of the EMT will be contacted.

Reporting

Reporting of site position or any issues EMT need to be made aware of will be escalated to the EMT member on call. A timely copy of the EMT On Call rota will be distributed in tandem with the Senior Manager on Call rota.

APPENDIX 16

Press release from Department of Health dated 4th April 2024

Press release

Minister Donnelly announces new measures to alleviate overcrowding at University Hospital Limerick

From Department of Health (/en/organisation/department-of-health/)
Published on 4 April 2024
Last updated on 5 April 2024

Minister for Health Stephen Donnelly today visited University Hospital Limerick (UHL) where he met with management, including Regional Executive Officer Sandra Broderick, the Health Service Executive (HSE) CEO Bernard Gloster, as well as consultants and other clinical leaders.

Nationally, so far this year we have seen a 11.5% (37k) increase in the number of people presenting at Emergency Departments (EDs) versus the same period in 2023. For those aged 75+ patient group the increase is 16% (7,000).

In spite of this, additional capacity coupled with on-going reforms mean that the number of patients on trollies has fallen by 10.4% (3.3k).

UHL has consistently the highest number of people waiting on trollies for admittance to a hospital bed in the country.

In 2024 to date, 17% of those who waited on trollies did so at UHL, a hospital which has 6% of Emergency Department attendances, and 6% of attendances of those over 75 years.

In UHL, in 2024 we have seen a 14% (2.4k) increase in the number of people presenting at ED versus the same period in 2023.

The number of patients on trolleys has increased by 49% (1.6k).

Of the five hospitals with the highest numbers of patients on trolleys, UHL is the only one showing an increase in trolley numbers for 2024.

Minister Donnelly said:

> "This continued problem is not acceptable to me as Minister, and it most certainly is not acceptable to the people of this region.

> "In an effort to alleviate the problem I have agreed with the HSE a number of measures which will, I hope, help:

- a procurement process has been initiated for the operation of the new 50 bed Community Nursing Unit in Nenagh as a step down sub-acute and rehabilitation facility for this hospital for one year until the first 96 bed block is opened
- we have decided to change the bed profile in this new block from 48 new beds to 71 new beds. I have also asked that recruitment commence 2024 for immediate readiness in 2025
- I have mandated that all steps are taken to accelerate the second 96 bed block to be built here at UHL, having sanctioned enabling works for that project last year. Those works have begun
- a further 20 permanent step down transition & rehab beds will be procured in Clare
- 16 additional fast build beds are to be commissioned onsite with this capacity to be available in advance of next winter's surge
- the opening hours of the region's three Acute Medical Assessment Units at Nenagh, Ennis and St John's are to be extended to 24/7 on a phased basis
- safe staffing will be extended to all wards in UHL as per the national rollout
- UHL is to be one of two national test sites for Acute Virtual Wards
- UHL will provide GP and Advanced Nurse Practitioner-on-the-door services for the ED in an effort to alleviate overcrowding and allow the ED staff to treat urgent and emergency patients in a more timely manner

> "These new measures come on top of a 41% increase in staff at UHL since 2019, and an addition of 108 beds since 2020. The budget allocation for this Hospital has increased by 44% since 2019 to €383 million in 2023."

Minister Donnelly also met with representative groups of nursing and NCHD staff. The Minister impressed on everyone he met, that those hospitals that perform best in terms of trollies are those which have changed the way they work to better suit the needs of the populations they serve.

The Minister said:

> "Those hospitals that are improving their performance, are doing so through a combination of increased resources - we have more beds and more staff right across our health service albeit not to the same extent as here in Limerick - and reformed work practices.

> "Therefore, I have asked and expect that we will see here in UHL the following:

- that senior decision makers are rostered on site, both in the Emergency Department and throughout the hospital, after hours and at weekends. UHL ranks 9th in the country for weekend discharges, that must improve There will be a progression to immediate rostering over six and where contractually possible seven days
- an All-of-Hospital approach to treating ED patients, including presence of non-ED consultants to support ED colleagues in the Emergency Department when necessary
- a strong patient flow team in place 7 days per week
- weekend access to scheduled diagnostics for ED
- that there be community and Health and Social Care Professional support for weekend discharge, with 7-day rostering
- a targeted campaign to increase the number of consultants on the Public-Only Consultant Contract in UHL. An improved deployment review of those on the POCC to extend decision-making capacity
- a single Mid-West Bed Management System and Patient Flow Team: All non-long stay beds – hospital and community will now come under one bed management system

and with one person managing flow

- that a Social Inclusion Hospital to Community Team will tackle the demographic and social challenges which lead to overutilisation of hospital pathways
- that the CAMHS Paediatric Liaison Team provide in reach into the paediatric wards to support children with mental health needs
- in terms of Community Chronic Disease Management team – we will redistribute CDM and ICPOP Teams to highest need areas of population
- all national clinical and reform programmes are to be deployed for the immediate benefit of the hospital. Central Referral Management and Patient-Initiated Reviews in scheduled care are to be introduced
- Senior Management on the Floor early mornings: There will be a reorganisation of working plans of Executive Management Team on site at UHL across the week to provide operational leadership and support to staff across the hospital. This is a proven method of enhancing performance

> "These measures have proved to be successful when deployed in Waterford, Mullingar, Beaumont and elsewhere and I expect that they will be successful when they are rolled out here in Limerick.

> "Reform and change are difficult, they challenge us all, but reform and change are required here in UHL if we are to provide the service the people of this region expect and deserve."

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APPENDIX 17

Standard form email sent to Senior Managers on 13th & 18th June 2024

From: Anne Marie Cullen <AnneMarie.Cullen@hse.ie>
Sent: Thursday 13 June 2024 18:19
To:
Subject: FW: UHL - Independent Investigation

Dear

It was noted in earlier correspondence from the Investigator, that all senior managers would be given an opportunity to make final observations in respect of possible recommendations in the Report of the Investigation where it might be inferred that the recommendations concerned could reflect on managers. It should be emphasised that a letter in identical terms is being sent to all senior managers interviewed and it should again be emphasised that the Report will not suggest any individual blame. Indeed you may consider that not all of the matters mentioned hereunder arise in the context of your duties.

A recommendation is under consideration which arises from evidence of a lack of clarity in respect of a number of matters:-

(a) **The operation of the protocol relating to decongestion in the ED**: It is acknowledged that the evidence suggests that senior managers, perhaps reluctantly in some cases , went along with the direction/mandate or recommendation of the PMIU (it is described in each of these terms by various witnesses) up until a decision was taken in respect of October 24th 2022 to recommence the use of ward trollies. It is also acknowledged that there was a regular use of ward trollies thereafter.

Notwithstanding this, nurse managers on the ground have given evidence that the position of the PMIU remained a factor as of December 2022. As examples of this the following evidence was given:-

(i) whilst acknowledging trolleys were going to wards end of 2022 said (emphasis added):
"In December that year, including up to the 31st December we had about 23 times trolleys went up because it got busier <u>but we were still discouraged in putting up trolleys."</u>

(ii) said:
"I suppose with the PMIU coming in July, that also affected decisions being made, I suppose looking at whether trolleys went to ward areas or not. September there was zero, October there was zero. You know, there were some elements of trolleys going up in November and I suppose 23 out of 31 days trolleys went up to ward areas in December. So it wasn't consistent, it was dependent on the Exec on call really."

The investigation has not seen any clear communication to nurse managers which set out the initial policy of going along with what was seen as the PMIU position followed by a reversal of that decision on October 24th 2022. In addition, in this context any further observations on why trollies did not go to the wards on the 17th December when they had on other occasions since October 24th would be useful.

(b) **The role of the Executive on Call in relation to decongestion**: It is acknowledged that there is a clear view from senior managers that the ultimate decision in this regard was one for the OpADON (a point which the

OpADON in question accepts). However, a number of nurse managers seemed to consider that the Executive on Call had a role which went beyond merely advising and supporting. As examples of this the following evidence was given:

(i) "It is quite challenging in that it depends on the Exec that you have on call, you know, whether trolleys go to ward areas, boarded patients go to ward areas, whether we open the surge areas, extra capacity. I suppose with the PMIU coming in July, that also affected decisions being made, I suppose looking at whether trolleys went to ward areas or not. September there was zero, October there was zero. You know, there were some elements of trolleys going up in November and I suppose 23 out of 31 days trolleys went up to ward areas in December. So it wasn't consistent, it was depending-- dependent on the Exec on call really."

(ii) Question: Sure. So the basic model would be that either, would I be right, either you or someone in your position would suggest to the exec on call or the exec on call might themselves ask what do we need to do and that might lead to a decision?

Answer: It is a 50/50, yes, but they would make the final decision

(c) **The Sepsis Forms:** Given that the evidence demonstrates that none of the nurses or doctors involved with Aoife on the night in question seem to have been aware that she had been referred as a sepsis suspect patient and had been triaged in a similar vein , the fact that the sepsis form was not filled in is of some relevance as it might have drawn attention to the sepsis risk. The practice whereby these forms were kept only in the Resus area (where, on the evidence , sepsis risk patients are normally placed after triage) but where Aoife was not sent to Resus due to that area being extremely crowded seems to have contributed to this situation. It might be inferred that there was insufficient clarity about the use of this form.

(d) **The process for category 2 patients being seen by doctors:** It is acknowledged that all concerned were working in extremely challenging conditions on the night in question by virtue of the large number of patients presenting coupled with the small number of staff on duty (contributed to by nurses being 5 below the allocated number and one doctor rostered not being available). It is clear that there was not strict adherence to chronological order within each triage category although there may well have been good reason for any departure. The process seems on the evidence to have been ad hoc and much dependant on individual nurses advocating for patients to individual doctors. It is appreciated that the EMEWS system (now in place) or similar could not have been implemented at that time given the demands which any such system would make on scares nursing resources. However, given that significantly challenging circumstances were not infrequent in ED (although not on the scale of the relevant weekend) it might be said that there could have been greater clarity as to how the system was to work in challenging circumstances when it is highly likely that senior doctors and nurses (who may have to assess the overall situation) are fully engaged in clinical work and unable to exercise some degree of overall assessment.

(e) **The obligations of the Executive on Call to follow up:** While the evidence of to the Inquest is acknowledged that answer is said to be "in hindsight". The Investigation has not seen any evidence of any instruction or statement which would have clearly indicated such a role in advance.

(f) **The co-ordination of the role of doctors in ED:** It is acknowledged that the evidence makes clear that each doctor has a particular assignment rostered and that the is the senior person. However it appears on the evidence that the decided himself that, at least for a period of time (there are different recollections as to for how long should work in Resus given the volume of patients there. It

would appear that this was a decision made by the [redacted]. It is appreciated that doctors on the ground may have to take decisions as to what patients they should attend to next but it might be said that there should be some accepted practice established to cover situations where a doctor is to depart from their rostered area not least where the effect of that decision was to leave only one SHO in the zones with an extremely large number of patients. If there is any guidance in that regard in existence the Investigation would be grateful to receive it.

I would request that any observations be made by close of business **Friday 21st June** to enable to Report to be finalised.

It should be noted that the Report is likely to go into some detail on the issue of the lack of resources in UHL and its impact on the ED (including the fact that the other Mid-West Region EDs were closed without, as Howarth recommended, Dooradoyle first being upgraded to meet the arising extra demand).

Finally, It should emphasised that no decisions have, of course, as yet been taken but that it is now necessary to give all concerned an opportunity to make any final submissions or observations (or indeed provide further evidence) before the Report is completed. I confirm that there are a small number of requests for information to which replies are awaited and should anything arise from those replies then such matters will, as in this letter, be brought to your attention to enable you to comment.

Yours sincerely

Anne Marie Cullen
On behalf of Judge Frank Clarke (Retired), Independent Investigator

Anne Marie Cullen, Solicitor|HSE Office of Legal Services|31/33 Catherine Street|Limerick|V94 Y27|
Phone: 087 7161118|Email: annemarie.cullen@hse.ie |

Anne Marie Cullen, Dlíodóir|Oifig Sheirbhísí Dlí FnaSS| 31/33 Sráid Chaitríona|Luimneach V94 AY27|
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From: Anne Marie Cullen
Sent: Tuesday 18 June 2024 12:32
To:
Subject: UHL Independent Investigation - Addendum to email of 13th June

Dear

Further to my email on behalf of the Investigator of June 13th, your evidence in respect of issuing a directive in October 2022 that trollies were to go to wards (once the threshold of 23 admitted patients on trollies in the ED was reached) has been put to in capacity as at the time. has responded with the following observation:

'In late October, as the winter surge began trolleys began to be moved again from ED to wards but this was not as a result of any directive formally communicated to us as operational managers. If there was a directive, we never got it.'

If you wish to make any further observations please do so, in conjunction with any observations you may wish to make in response to my email of June 13th.

Yours sincerely

Anne Marie Cullen
On behalf of Judge Clarke (Retired)

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APPENDIX 18

Replies to email from the Investigation dated 13th & 18th June 2024

From: [redacted]
Sent: Friday 21 June 2024 15:06
To: [redacted]
Cc: [redacted]
Subject: FW: UHL - Independent Investigation
Importance: High

Dear [redacted]

In relation to your email below, please see attached response with referenced documentation from [redacted] UL Hospitals for your attention.

Kind regards,

[redacted]

#hello my name is

[redacted]

Ospidéil OL
UL Hospitals
Working together caring for you

Ref: CC/TH
21st June 2024

Ms. Anne Marie Cullen
Solicitor
HSE Office of Legal Services
31/33 Catherine Street
Limerick
V94 Y27
Sent via email to: annemarie.cullen@hse.ie

Re: Correspondence of the 13th June 2024 and the 18th June 2024

Dear Anne Marie

Your email of the 13th June 2024 refers and my responses to the issues raised are as follows: (Within these responses, references to the Escalation Plan are to the "UL Hospitals Winter Escalation Framework 24th May 2022" that has previously been furnished to you. The "Trigger Process Flow Plan" as referenced in the Framework document has also been furnished to you).

(a) The operation of the protocol relating to decongestion in the ED

In the first instance, it is not a case of the policy of placing trolleys on wards being either "encouraged" or "discouraged" ; rather, the policy was to be followed once the conditions set out in the Escalation Plan were present.

Contrary to the phrasing of query (a), the reference to "discouraged in putting up trolleys" in the extract from evidence does not appear to allude specifically to the PMIU – indeed, there is no indication as to who is alleged by to have "discouraged" the practice.

It is possible that the issue of discouragement relates to the involvement of the INMO, which wrote to me on the 25th October 2022 (the day after the decision to place trolleys on wards was re-instated) and to whom the Hospital policy in respect of wards was confirmed in correspondence dated 8th November 2022 and thereafter once more at the meeting of the ED/INMO Forum on the 28th November 2022. It was explained on the latter occasion as follows:

"Discussion re trolleys going back on ward. agreed that trolleys should not be on wards and is something that is not advocated or supported however the ED risk needs to be mitigated and this is only done when absolutely required."

I believe the above to be a wholly accurate synopsis of the position in respect of the policy of placing wards on trolleys.

Ospidéil OL
UL Hospitals
Working together, caring for you

For the avoidance of any doubt, it is certainly not the case that in UHL discouraged the placing of trolleys on wards once the decision had been made by the Extraordinary Executive Committee on the 23rd October 2022.

In respect of the comments of is obviously correct in stating that the intervention of the PMIU affected decisions in respect of trolleys going to wards ; the policy was suspended in response to the PMIU intervention and that remained the position until the decision taken at the Extraordinary Executive meeting on the 23rd October 2022.

However, comments are erroneous on a number of other fronts:

(a) It is incorrect to state that there were zero trolleys going to wards in October 2022: trolleys resumed going to wards from the 24th October 2022 and trolleys went to wards on days thereafter in October 2022. Please see template below, numbers on wards are reflective of activity.

Dates where ward trolleys placed	Total Trolleys UHL
24-Oct	17
25-Oct	10
26-Oct	5
27-Oct	4
28-Oct	2
29-Oct	1
30-Oct	1
31-Oct	2
01-Nov	4
02-Nov	13
03-Nov	11
Total	**70**

(b) Trolleys went to wards on 23 out of 31 days in December 2022 because on those days the Escalation Plan that provides for trolleys going to wards became operational due to the number of admitted patients in the ED. The only date that the Escalation Plan became operational without trolleys going to wards was the 17th December 2022 and to date there has not been any clear explanation for that anomaly.

(c) suggestion that *"it wasn't consistent, it was dependent on the really"* ignores the following facts :

(a) The circumstances in which escalation procedure were to be implemented were clearly set out in the Escalation Plan and they were not subject to any inconsistency or ambiguity.

(b) The implementation of the Escalation Plan during the out of hours period was the responsibility of the it was not the responsibility of the

Ospidéil OL
UL Hospitals

PMJU were a visiting team to improve unscheduled care performance over a 6 week period. As such they would not have had the authority to issue cessation of ward trolley directive therefore their requirements were set out as a target to achieve as headlined in various presentations to [redacted] and front line staff. It was the constant narrative to de-escalate the site. All presentations were prescriptive to 'remove ward trolleys'.

The decision to resume placing trolleys on Wards was communicated to the Weekly Teleconference of Directors of Nursing & Midwifery on the 24th October 2022 (attached). The practical implications of the resumption of the practice was also referenced in the DOSH records (communications received by [redacted]) dated 25th October 2022 – If a patient is identified for discharge at ward level, the ward will receive a trolley. Patients to go up in chronological order (copy attached). These instructions were updated following DOSH meeting on the 4th November 2022.
DOSH of 4/11/22 – All wards that previously received a trolley will receive 1 immediately. As soon as a patient is identified for discharge the ward will receive a 2nd trolley – 1st patient to remain on trolley.

Referencing the Extraordinary Executive Huddle held on the 23rd October 2022, [redacted] was in attendance and instruction relayed to front line staff via daily DOSH meetings and reflected in minutes of the DOSH meetings.

(b) The role of the [redacted] in relation to decongestion

It is noted that the [redacted] in question acknowledges that it was [redacted] decision to implement of the Escalation Plan when the applicable circumstances prevailed in the ED. The suggestion that the implementation of the Escalation Plan was in any way dependent upon the Executive on Call is erroneous.

[redacted] comments (by way of response to a very specific proposition put to her) relate to "a decision" – for present purposes it is assumed that the question [redacted] was asked related to the circumstances in which the Escalation Plan was implemented. If that is indeed the case, then [redacted] comments are erroneous in suggesting that the implementation of the Escalation Plan was in any way dependent or contingent upon any intervention on the part of the [redacted]. The Trigger Process Flow Plan (as referenced in the Escalation Plan) does require notification to the [redacted] of the implementation of the Escalation Plan from Step 3 thereof and thereafter. It is accepted that the [redacted] regularly contacted the [redacted] to give notice of the implementation of the Escalation Plan by moving trolleys to wards and I would not seek to deprecate or discourage that contact.

(c) The Sepsis Forms

I consider this to be a matter for the [redacted]

(d) The process for category 2 patients being seen by doctors

I consider this to be a matter for the [redacted]

(e) The obligations of the [redacted] to follow up: Please refer to the final sentence of the response to the query at (b) above. Evidently, in the circumstances of the 17th December 2022, Step 3 of the process was not completed and the no such notification was provided. In circumstances where the [redacted] had been notified that the circumstances in the ED were such as to require implementation of the Step 3 process, it is agreed that it would have been appropriate in hindsight for [redacted] to query why [redacted] had not received notification of the process having been implemented following the 90 minutes time frame set out for that process within the Trigger Process Flow Plan.

(f) The co-ordination of the role of doctors in ED:

I consider this to be a matter for the [redacted]

In respect of your further email of the 18th June 2024 referring to the comments of [redacted] I note that [redacted] acknowledges that the policy of placing trolleys on wards was resumed towards the end of October 2022. The resumption of the policy was communicated to the Weekly Teleconference of Directors of Nursing & Midwifery on the 24th October 2022 (as set out above) and [redacted] would have learned of that immediately thereafter.

Yours sincerely,

1-2

Weekly Teleconference Directors of Nursing and Midwifery		
Date: 24/10/2022 Chair – P O'Gorman		
Attendees:		
Apologies:		
	Log	Action
1. (Nenagh)	• +3, 55 patients • Acuity high, high supervision • LIU – 2nd ANP out sick, Dr present all week. ANP on Cvd leave due to return Wednesday • Radiology – no cover at moment for Sunday, working on same • SN on ND had bad fall this morning, in LIU • Onsite all week • Thursday evening – healthy Ireland talk	
2. (Ennis)	• +2, LIU busy over weekend • MAU 17 booked for today, slots available • Flu vaccine continues on site today • Staffing stable	
3. (Croom)	• Transfer expected, due out yesterday but transport issues • No issues over weekend • 1 pt in Maigue waiting Rehab in Dun Laoighaire, becoming aggressive, managing same • Anaesthetic cover may be an issue tomorrow	
4. (St. John's)	• Full today, issues over weekend re transfers, managing same • No incidents over weekend • LIU busy over weekend	
5. (Maternity)	• Busy weekend, all stable • No cvd inpatients • Offsite this morning review officers training • Onsite all week	

6. [redacted] (Peri-Op)	• Alleged patient assault in SSAU Friday, recollection of events in progress, Gardaí called • SAFER meeting tomorrow • Offsite Wed-Fri • Nursing governance issue as a result of nursing leave	
7. [redacted] (Medicine)	• High attendances (200 -250) • Decision made by exec to put trolleys on wards, fill surgical and OPAC • 14 trolleys on wards, 6 in OPAC, 11 in SDW • High risk 4C and 8C over weekend, absconded but got back • High acuity on wards • No falls or SREs • Discharges low • Fannin pop up isolation units on display today	[redacted] if they can visit each site
8. [redacted] (Cancer Services)	• Very busy last week • Acuity high • Academic partnership meeting today and Magnet meeting • Review officer training later today	
9. [redacted] (Informatics)	• Visiting Dell this morning • Clinical leadership continues on Thursday	
10. [redacted]		

1.4

DOSH

- Year	- 2022
- Date/ Time	- 25th October 2022 @ 9am
- Hospital	- University Hospital Limerick
- Chairperson	-
- Attendees	-
- Venue	Boardroom, Ground Floor, Nurses Home, UHL & Teams

- Item –		- Action & Responsibility
- Review Action Log	- Clear referral process with visibility needed. Referral time-frame data to be captured but difficult to collate. Digital platform used by some specialities. Integrated pathway mapping meeting next week. - R2G data to be showcased weekly at DOSH. Where engagement is poor; resources and education will be looked at. - National Team to assist with NCHD education piece. - Visibility on ward participation for R2G. Areas that are engaging and areas with less engagement will be showcased. 4 Peri-Op wards are awaiting screens for R2G. - Productive discharge meeting held on 19th October with Associated CD, HOOS, Medicine and patient flow. Challenges identified with actions to be completed. Patient Flow to provide examples of responses received on wards and all responses will be highlighted at DOSH. Nursing are the biggest influencers at ward level. Discussion re future HIQA visits. will clarify who will meet with HIQA when on-site. Query to confirm. Flu Vaccinations ongoing every Monday and will expand to Houston Hall, CERC and CCU. Flu Vaccinations also ongoing in Scoil Carmel with a bus services provided. Discussion around visitors and incident in Ward 3B yesterday. confirmed that the Visitors App must be used for all visits. Josie Dillon to forward communication to re incident on Ward 3B yesterday. Communication piece re Visitors App to go out. Meeting planned for 25/10/2022. Escalation plan. Concern regarding the escalation plan for admitted patients in ED. Raised by as a safety concern. is meeting with to discuss the escalation plan.	-

- Item –		- Action & Responsibility
	- RAMU - [redacted] confirmed meeting on 21st September with key stakeholders. SOP will be ready today 20th October. Issue re nurse resources between 8am and 9am. [redacted] to link with [redacted] re nursing resource between 8am and 9am. - Weekend huddle at 9.30am this weekend on existing number and may transition to TEAMS. HOOS to send e-mail Friday to confirm 9.30am huddle over weekend. - Short supply of Aspen collars on-site. [redacted] to follow-up re supply of Aspen collars. - Pop-Up Isolation pod will be available for viewing on Monday 24th October. St. Johns invited on-site to view pod. [redacted] to circulate times of Pop-up isolation pod. - OPAC open Monday 17th October and will go live tomorrow with 5 beds initially. Medicine to link with Community to map possesses. Opening hours will be 8-5 with a plan to progress to 8-8. [redacted] thanked all staff that worked over the weekend including Maintenance and Hygiene. [redacted] will answer all queries off-line. [redacted] requested daily OPAC figures. No ID Consultant on Mondays and Fridays due to sick leave. May have an impact on OPAC. - MD-CIT unable to take referrals until after 10th October due to issues with supply of Baxter infusion pumps. [redacted] and [redacted] to link Community to discuss MD-CIT referrals. Another option needs to be sourced. - Issues with supply of Braun infusion set for ED. [redacted] to link with [redacted] in theatre re supply of Braun infusion sets. Medicine to link with other hospitals for supply. - Issue with Ambulance over weekend – Support needed for transfers to Model 2's. Nenagh confirmed possible issues with transfers for 4th September. Patent Flow to link with [redacted] to discuss ambulance cover. [redacted] to link with [redacted] in Ambulance for transfers for 4th October. - Medical rep required to attend DOSH. [redacted] to link with [redacted] re Medical rep. - [redacted] to link with [redacted] and revert with weekly figures. - Community to forward daily bed availability figures to Discharge Team. - [redacted] commenced R2G and SAFER training with CNM's in Nenagh on 26th September with a number of complex discharges confirmed. PPBI assistance needed to build long-stay report for Nenagh. [redacted] to re-visit Nenagh in 2 weeks to commence training with staff nurses, NCHD's and Allied Health. [illegible] training may be required for Ward Clerks. - [redacted] to look at SHO deficits and confirm medical Manpower rep. [redacted] to receive daily SHO/ Reg deficit figures.	
- Today's Site Report	- [redacted] highlighted the HCMT report for 25th October 2022 as attached. - High number of patients in ED.	-

- Item -		Action & Responsibility
	- 265 patients through yesterday. - [redacted] - 2 Surge areas open. - Security special to be reviewed for transfer to Croom. - Blocked Beds – 3C x 2, 4A x 1, 4B x 1, 8D x 1. - HCMT pm is changed to 2pm, on 01-389-5325/* 834953#	
- Patient Flow	- DTOC – 30. - Long Stay Tuesday today. - R2G Discharges – 11 Medical and 4 Peri-Op - R2G Transfers – Ennis x 7, Nenagh x 7, St. John"s x 10	-
- Community Capacity	- Figures confirmed attached. - Long-stay room available in St. Ita's. - Push to transfer high numbers to community. - Community to confirm Medical cover in St. Josephs and St. Camillus'	- [redacted] to link with [redacted] re complex discharge to St. Ita's. - [redacted] to confirm Medical cover.
- Model 2s	- Figures confirmed attached. - Issue with Anaesthetic cover in Croom. Patients deferred to tomorrow. - 3 IPC female beds available in St. Johns. - Transfer issues with 2 patients identified for Nenagh and Ennis on 24th October. -	- [redacted] to link with Patient Flow re available IPC beds. - Patient Flow to follow-up re patients identified for transfer to Ennis and Nenagh on 24th.
- Critical Care	-	-
- Diagnostics	- Figures confirmed attached.	-
- Scheduled Care		
- Priority Patients	- Names with Bed Management am.	-
- Staffing	- s/n x 19, HCA x 12.	-
- COVID- 19	- 29 + 3 ED	-
- IP&C	-	-
- Adverse Events	-	-

Item –		Action & Responsibility
AOB	- Discussion re the use of pop-up tents for patients. - Discussion re elective patients. Tina Fitzgerald confirmed beds available for electives. - Issue re porters working under protest in ED (OPAC). - Risk re high numbers of patients awaiting admission. Tough discussions needed for discharges. If a patient is identified for discharge at ward level; the ward will receive a trolley. Patients to go up in chronological order. - Transport issues. Meeting scheduled for patient transfer services on 26th October.	- [redacted] to confirm if 1 to 2 pop-up isolation tents can be used. - [redacted] to link with Facilities for update.
-	- Next Meeting: Wednesday 26th October in Classroom 1, Ground Floor, UHL, and via Teams at 9am.	-

Discharges + Transfers

	Sat	Sun	Mon	Tue	Wed	Thurs	Fri
Total Discharges		17	59				
D/Cs before 10am							
D/Cs after							
Transfers Total		7	14				

Diagnostics

	Mon	Tue	Wed	Thurs	Fri
MRI	54		60		
CT	56		64		
Ultrasound	76		75		

Model 2's					
Location	Mon	Tue	Wed	Thurs	Fri
Nenagh	0 + 3-4 potential discharges	1 bed awaiting patient from UHL on 24th Oct + 3-4 potential discharges			
Ennis	In Surge 2 corridor beds available + 2-3 potential discharges	1 + 4-5 potential discharges			
St. Johns	11 identified discharges	5 vacant – 2 male and 3 ICP female + 5 identified discharges at 12pm + potential discharges throughout the day			
Croom	5 identified discharges	3 identified for transfer from UHL + 6 potential discharges			

Community Capacity

	Mon		Tues		Wed		Thurs		Fri	
Location	Reh	LTC	Reh	LTC	Reh	LTC	Reh	LTC	Reh	LTC
St. Ita's	0	3	0	3						
St. Camillus	9	0	8	0						
St. Josephs	2	3	3	1						
Hosp. of Assu	1	0	3	0						
St. Conlon's				0						
Dean Max		2		2						

CIT LK	Capacity	Capacity
CIT Tipp	Capacity	Capacity
CIT Clare	Capacity	Capacity
OPAT	11 OPAT out with 4 pending	12 OPAT out + 2 pending

1-4

DOSH

Year	2022
Date/ Time	4th November 2022 @ 9am
Hospital	University Hospital Limerick
Chairperson	[redacted]
Attendees	[redacted]
Venue	Classroom 1, Ground Floor, Nurses Home, UHL & Teams

Item –		Action & Responsibility
Review Action Log	- Discussion re the use of pop-up tents for patients. - PPBI need to work on putting more data on dashboards. - OPAC – patient movement needs to be reflected on systems. - [redacted] confirmed; extra support for flow (CNM 2) through Winter Plan. - All DOSH members play an important part in accountability and responsibility and issues raised are not individually based. We all need to be careful how we address issues and need to be respectful and professional. - Planning and training needed for Flu. Plan to schedule meeting next week and include [redacted] - Clear referral process with visibility needed. Referral time-frame data to be captured but difficult to collate. Digital platform used by some specialities. Integrated pathway mapping meeting next week. - R2G data to be showcased weekly at DOSH. Where engagement is poor; resources and education will be looked at. - National Team to assist with NCHD education piece. - Visibility on ward participation for R2G. Areas that are engaging and areas with less engagement will be showcased. 4 Peri-Op wards are awaiting screens for R2G. - [redacted] – ED escalation plan discussed. Focus on getting patients out of ED earlier in the morning. Patient Flow confirmed; Prescriptions/ transfer letter/ resus status needed prior to transfer. [redacted] confirmed patient resus status can be	- [redacted] to confirm if 1 to 2 pop-up isolation tents can be used. - [redacted] to link with PPBI re LST data.

- Item –		- Action & Responsibility
	confirmed on admission and this will eliminate one step. Issue re Consultants handing over patients post 9am to be escalated. Previous minutes confirmed [redacted] and [redacted] to meet re escalation plan. - Communication of DOSH minutes can be cascaded down through Directorates. CNM from Medicine and Peri-Op invited to attend DOSH. - October Bank Holiday weekend was extremely busy. Extra resources provided in transport and patient flow. Funding available through Winter Plan. Ethos of 5/7 days needs to change to 7/7. Physician piece needs to be done around weekend discharges/ transfers. Weekend preparation needs to start on Wednesdays with information and processes in place. - Erthapenum supply issue for OPAT services, potential in-house pharmacy to supply. [redacted] to follow-up with diagnostics. Issue resolved. - Issue with teas/ coffees in ED night of 25th October. [redacted] to link with [redacted] re issue with teas/ coffees in ED at night. - Issue re porters working under protest in ED (OPAC). [redacted] to link with Facilities for update. Issue resolved. - Productive discharge meeting held on 19th October with Associated CD, HOOS, Medicine and patient flow. Challenges identified with actions to be completed. Patient Flow to provide examples of responses received on wards and all responses will be highlighted at DOSH. Nursing are the biggest influencers at ward level. - Discussion re future HIQA visits. [redacted] will clarify who will meet with HIQA when on-site. Query [redacted] to confirm. - Flu Vaccinations ongoing every Monday and will expand to Houston Hall, CERC and CCU. Flu Vaccinations also ongoing in Scoil Carmel with a bus services provided. - Discussion around visitors and incident in Ward 3B yesterday. [redacted] confirmed that the Visitors App must be used for all visits. [redacted] to forward communication to [redacted] re incident on Ward 3B yesterday. Communication piece re Visitors App to go out. Meeting planned for 25/10/2022. - Escalation plan. Concern regarding the escalation plan for admitted patients in ED. Raised by [redacted] as a safety concern. [redacted] is meeting with [redacted] to discuss the escalation plan. - RAMU – [redacted] confirmed meeting on 21st September with key stakeholders. SOP will be ready today 20th October. Issue re nurse resources between 8am and 9am. [redacted] to link with [redacted] re nursing resource between 8am and 9am. - Weekend huddle at 9.30am this weekend on existing number and may transition to TEAMS. HOOS to send e-mail Friday to confirm 9.30am huddle over weekend.	

- Item –		- Action & Responsibility
	Short supply of Aspen collars on-site. ███ to follow-up re supply of Aspen collars. Pop-Up isolation pod will be available for viewing on Monday 24th October. St. Johns invited on-site to view pod. ███ to circulate times of Pop-up isolation pod. OPAC open Monday 17th October and will go live tomorrow with 5 beds initially. Medicine to link with Community to map pathways. Opening hours will be 8-5 with a plan to progress to 8-8. ███ thanked all staff that worked over the weekend including Maintenance and Hygiene. ███ will answer all queries off-line. ███ requested daily OPAC figures. No ID Consultant on Mondays and Fridays due to sick leave. May have an impact on OPAC. MD-CIT unable to take referrals until after 10th October due to issues with supply of Baxter infusion pumps. ███ and ███ to link Community to discuss MD-CIT referrals. Another option needs to be sourced. Issues with supply of Braun infusion set for ED. ███ to link with ███ in theatre re supply of Braun infusion sets. Medicine to link with other hospitals for supply. Issue with Ambulance over weekend – Support needed for transfers to Model 2's. Nenagh confirmed possible issues with transfers for 4th September. Patient Flow to link with ███ to discuss ambulance cover. ███ to link with ███ in Ambulance for transfers for 4th October. Medical rep required to attend DOSH. ███ to link with ███ re Medical rep. ███ to link with ███ and revert with weekly figures. Community to forward daily bed availability figures to Discharge Team. ███ commenced R2G and SAFER training with CNM's in Nenagh on 26th September with a number of complex discharges confirmed. PPIM assistance needed to build long-stay report for Nenagh. ███ to re-visit Nenagh in 2 weeks to commence training with staff nurses, NCHD's and Allied Health. IPMs training may be required for Ward Clerks. ███ to look at SHO deficits and confirm medical Manpower rep. ███ to receive daily SHO/ flag deficit figures.	
- Today's Site Report	- ███ highlighted the HCMT report for 4th November 2022 as attached. - High volume of patients in ED. 97 in the department with 42 bed booked. - 223 patients through Ed yesterday. - Surge – SDW x 7. - Issue re on-call Medical team declining patients' referrals after 7am. ███ to	- ███ to look into issue re on-call Medical cover. ███ to escalate. - Patient Flow to link with IP&C re blocked beds due to IP&C.

Item		Action & Responsibility
	escalate. - High number of blocked beds due to IP&C issues. - HCMT pm is changed to 2pm, on 01-889-5325/ 834953#	
Patient Flow	- DTOC – 12 R2G Discharges – 9 - R2G Transfers – Ennis x 7, Nenagh x 3, St. Johns X 14, Croom x 0	-
- Community Capacity	- Figures confirmed attached. - ErtHapenum supply issue for OPAT services resolved. - 2 rehab beds in St. Camillus, IP&C issue in Treaty.	[redacted] to link with Sian [redacted] re booked Rehab beds in St. Camillus'
- Model 2s	- Figures confirmed attached. - Model 2's to confirm Physicians and Patient Flow on-call for the weekend.	Model 2's to confirm weekend on-call Physicians and Patient Flow.
- Critical Care	-	-
Diagnostics	- Figures confirmed attached. - Figures have improved over the last 2 weeks.	-
- Scheduled Care		
- Priority Patients	- Names with Bed Management am.	-
- Staffing	- s/n x 27, SHO x 1 (S/L), ED REG x 1 (position unfilled). - ED to confirm weekend deficits.	- [redacted] to confirm potential weekend deficits for ED.
- COVID-19	-	-
- IP&C	- Patient Flow to link with IP&C re blocked beds due IP&C issues.	-
- Adverse Events	-	-
- AOB	- Decompress ED. All wards that previously received a trolley will receive 1 immediately. As soon as a patient is identified for discharge the ward will receive a 2nd trolley. 1st patient to remain on trolley. ED and Patient Flow to be mindful of suitable patients to go into beds. Trolley will be returned back. Support all discharges over the weekend. - Encourage all staff to attend for Flu vaccination. Vaccinations take-up is poor. Timetable for November below. - Remind all staff to turn off lights and power off computers for the weekend. - Weekend huddle at 9.30am.	-

- Item –		- Action & Responsibility
-	- Next Meeting: Monday 7th November in Classroom 1, Ground Floor, Nurses Home, UHL, and via Teams at 9am.	-

Discharges + Transfers

	Sat	Sun	Mon	Tue	Wed	Thurs	Fri
Total Discharges	20	11	56	54	68		
D/Cs before 10am							
D/Cs after							
Transfers Total		11	11	13	15		

Diagnostics

	Mon	Tue	Wed	Thurs	Fri
MRI	42	44	31	40	
CT	65	52	61	46	
Ultrasound	46	53	48	45	

Model 2's					
Location	Mon	Tue	Wed	Thurs	Fri
Nenagh	1 female + 4 potential discharges	At plus 4 + 2 potential discharges	7 potential discharges	2 vacant rooms + 4 potential discharges	
Ennis	5 potential discharges	At plus 3 + 8 discharges	3 potential discharges	4 vacant + 4 potential discharges	
St. Johns	1 male & 1 female + 2 identified discharges with further discharges throughout the day	2 male + later discharges	2 vacant (1 male & 1 female) + 5 potential discharges	Plus 2 + 7 potential discharges	
Croom	2 for transfer + 5 potential discharges	1 for transfer + 5 discharges	2 for transfer + 4 potential discharges	2 for trauma	

Community Capacity										
	Mon		Tues		Wed		Thurs		Fri	
Location	Reh	LTC	Reh	LTC	Reh	LTC	Reh	LTC	Reh	LTC
St. Ita's	2	2	3	2	3	1	1	0		
St. Camillus	3	0	4	0	Treaty x 3	1 query IP&C issue	2	0		
St. Josephs	0	1	5	0	4	0	4	0		
Hosp. of Assu	5 single rooms	0	5	0	0	0	3	0		
St. Conlon's				0				0		
Dean Max		2		2				2		
CIT LK			Capacity		Capacity		Capacity			
CIT Tipp			Capacity		Capacity		Capacity			
CIT Clare			Capacity		Capacity		Capacity			
OPAT			15 OPAT out		14 OPAT out with 6 pending.		15 OPAT out.			

Flu Vaccination timetable for November.

	07/11/22	08/11/22	09/11/22	10/11/22	11/11/22
Week 6	UHL – H&W centre 2pm – 5.30pm	UMHL- Labour Ward 8.30am-10:30am		Nenagh Hospital - Gynae Unit 9am-4.30pm	
		UHL - CERC 9am-11am		St. John's Hospital - Phlebotomy Clinic 9:30am-12noon	
		UHL - ED 2pm-6pm			
	14/11/22	**15/11/22**	**16/11/22**	**17/11/22**	**18/11/22**
Week 7	UHL – H&W centre 2pm – 5.30pm	UHL - all wards 9am-1pm		UMHL- Labour Ward 10:30am-12:30pm	
	Nenagh Hospital - Gynae Unit 8am-4:30pm				
	Ennis Hospital - Former LIU 9am-1pm				
	21/11/22	**22/11/22**	**23/11/22**	**24/11/22**	**25/11/22**
Week 8	UHL - H&W centre 2pm – 5.30pm	Nenagh Hospital - Gynae Unit 8am-4.30pm			UMHL- Labour Ward 9am-11am
		UHL – all wards 9am-1pm			
	28/11/22	**29/11/22**	**30/11/22**	**01/12/22**	**02/12/22**
Week 9	UHL – H&W centre 2pm – 5.30pm	Nenagh Hospital - Gynae Unit 8am-12:30pm			
	Ennis Hospital - Former LIU 9am-1pm				

From: [redacted]
Sent: Monday 24 June 2024 09:32
To: Anne Marie Cullen <AnneMarie.Cullen@hse.ie>
Cc: [redacted]
Subject: RE: UHL - Independent Investigation

Dear Ms Cullen,

Further to your email of the 13th June 2024, with regards to the issues raised my final observations are:

(a) The operation of the protocol relating to decongestion in the ED:
In respect to comments from [redacted] it is not a case of the policy of placing trolleys on wards being discouraged, rather the policy was to be followed which was clearly set out in the escalation plan.
[redacted] is correct in stating that the intervention of the PMIU affected decisions in respect of trolleys going on wards. The policy was suspended in response to the PMIU intervention and that remained the case until a decision was taken at the Extraordinary Executive Huddle on 25th October 2022.
The [redacted] position in respect of the policy of placing trolleys on wards is that trolleys should not be on wards, however the ED risk needs to be mitigated and this is only done when absolutely required.

(b) The role of the [redacted] in relation to decongestion:
The triggers in which the escalation procedure are to be implemented are clearly set out in the Escalation Plan, the implementation of the Escalation Plan during out of hours is the responsibility of the [redacted] it is not the responsibility of the [redacted] I am very clear from a governance point of view that out of hours the [redacted] is in charge of the site. An Escalation Plan is in place and should be followed by the [redacted] The [redacted] is in place to provide support to the [redacted]

(c) The Sepsis Forms - The [redacted] and [redacted] should respond to this query

(d) The process for category 2 patients being seen by doctors - [redacted] should respond to this query

(e) The obligation of the [redacted] to follow up:
I am very clear from a governance point of view that the [redacted] is in charge of the site. An Escalation Plan is in place and should be followed by the [redacted] The [redacted] is in place to provide support to the [redacted]
In relation to the 17th December 2022, the evidence is that step three of the process was not completed and the [redacted] did not receive notification.

(f) The co-ordination of the role of doctors in ED - [redacted] should respond to this query

In respect of your further email dated the 18th June, I wish to advise that I have no further observations.

Yours sincerely,

[redacted]

[redacted]

[redacted]

From: [redacted]
Sent: Friday 21 June 2024 13:53
To: Anne Marie Cullen <AnneMarie.Cullen@hse.ie>
Cc: [redacted]
Subject: RE: Independent Investigation UHL - Addendum to Email of June 13th 2024

Dear Anne Marie.

I refer to your emails dated 13th and 18th of June.

I respectfully refer Justice Clarke to my previous detailed interview and documentation sent to the review team. and trust that this is sufficient information on which to carry out his function.

I further note that the escalation plan in operation at the time set out the steps to be followed and the appropriate accountable officers are referenced therein.

If any further clarity is required please so not hesitate to contact me.

Thank you

Kind Regards

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Strictly Private & Confidential
Mr Justice Frank Clarke
Independent Investigation
31/33 Catherine Street
1st Floor Office
Limerick
V94 AY27
By email only: AnneMarie.Cullen@hse.ie

21st June 2024

Dear Justice Clarke,

You write regarding the opportunity to make final observations in respect of possible recommendations in the report, however, said recommendations are not outlined rather the area/subject around which recommendations are under consideration are listed.

Notwithstanding this I will respond as best possible to the areas highlighted without prejudice.

a) **The operation of the protocol relating to decongestion in the Emergency Department.**

I note it is acknowledged that there was regular use of ward trolleys after 24th October 2022, this is factually correct.

I do not believe there was any confusion regarding the escalation process and its implementation. It was the organisational policy at the time. The placement of ward trolleys most certainly was not discouraged by the Executive Management Team. There was a clear escalation plan in place to be followed. The implementation of the escalation plan and the placement of ward trolleys out of hours was a matter for the Operational Assistant Director of Nursing, the Senior Site Manager on site out of hours. Its implementation was not the responsibility of the Executive on Call.

b) **The role of the Executive on Call in relation to decongestion.**

The Operational Assistant Director of Nursing is the senior site manager on-site out of hours. The Executive on call is there to support the site, support the Operational Assistant Director of Nursing and escalate matters where required.

c) The Sepsis forms

It is most regrettable that the Sepsis Six form was not instigated at triage.

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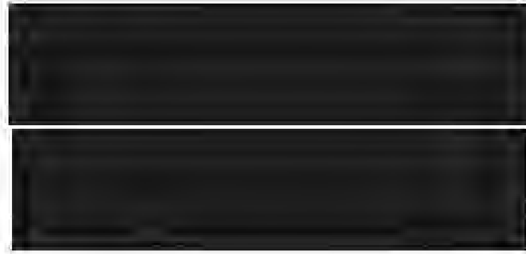

d) The process for Category 2 patients seen by doctors.

The night in question was most challenging for all staff and indeed patients. Chronological order while objective, cannot substitute for perceived clinical need with clinical prioritisation constantly changing.

Blindly following chronological order at the time would have been misconceived and would negate the use of clinical judgment by staff within the ED.

The system was ad hoc as there was an insufficient staffing level to implement any structured system such as the EMEWS system that has now been implemented with the benefit of the funding for additional staff as provided by the Minister.

e) The obligation of the Executive on call to follow-up.

On a personal note as [redacted] I do not follow up every instruction I issue; I expect them to be followed. I'm sure the [redacted] had a valid expectation that the instruction would be followed. Given the level of congestion in the Emergency Department follow-up would not seem inappropriate. Which the [redacted] acknowledged "in hindsight".

f) The co-ordination of the role of doctors in the Emergency Department.

Standard practice is for the most senior doctor to deploy available staff to the required areas. It is clear that Resus was a crisis point that night given the volume of patients in the Resus area. The [redacted] appears to have used his own initiative to attend Resus to decompress this area.

Should you require any further clarification or input, I remain at your disposal.

Yours Sincerely,

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