

Report into the death of Mr Patrick J Walsh

An Independent Private Inquiry:  
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## **Preface**

This report presents the findings of a private, non-statutory, independent inquiry into the tragic death of Mr Patrick Joseph Walsh in Monaghan Hospital in the early hours of 14<sup>th</sup> October 2005.

The reviewers' remit was:

***“To examine the circumstances pertaining to the death of Mr Patrick Walsh at Monaghan Hospital on 14th October 2005.” The scope shall cover the period commencing with the admission of Mr Walsh to Our Lady of Lourdes Hospital, Drogheda on 21<sup>st</sup> September, 2005 and will focus on clinical management but also examine to what extent non-clinical factors may have influenced the care received by Mr Walsh.”***

(For full Terms of Reference see Appendix 1)

This report makes a number of recommendations in the sincere hope that the lessons learned from this unnecessary loss of life are used in the development of new protocols and arrangements leading to good practice, which, if implemented within the healthcare services throughout the hospitals in the North-East region, will minimise or eliminate the risk of recurrence of such a tragic loss.

**The implementation of the recommendations within this report is a matter for consideration by the Health Service Executive North East and ultimately by the Department of Health and Children.**

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## **1 Executive Summary and Recommendations**

- 1.1 The late Mr. Walsh (d.o.b 31.03.29) died as a consequence of catastrophic recurrent haemorrhage from a duodenal ulcer while an in-patient in Monaghan Hospital.
- 1.2 The reviewers believe that the clinical management, relating to resuscitative efforts and clinical care during the fatal haemorrhage, by the staff in Monaghan Hospital was appropriate and beyond criticism.
- 1.3 Mr. Walsh had initially been successfully and appropriately treated for his bleeding ulcer while an in-patient in Our Lady of Lourdes Hospital (LOL), Drogheda.
- 1.4 The reviewers believe that the management of Mr. Walsh while in LOL Hospital was appropriate and beyond criticism.
- 1.5 Despite requests using appropriate telephone communication the Monaghan doctors were unable to arrange the transfer of Mr. Walsh to either LOL or Cavan Hospital although there were critical care beds available in both hospitals.
- 1.6 The reviewers believe that the failure of the on-call consultant in Monaghan Hospital to make direct telephone communication to the on-call consultant in the other hospitals or to consider the option of directly transferring Mr Walsh by ambulance fell short of good clinical practice. The reviewers also believe that the unwillingness of surgeons in LOL and Cavan Hospitals to immediately accept Mr Walsh was unacceptable.
- 1.7 The inquiry has revealed systematic evidence of serious process failure at almost all levels of activity apart from nursing care. This process failure resulted in an inability to achieve transfer of the patient. For example the on-call consultant in Cavan hospital was working under a policy that effectively precluded him from undertaking major GI surgical procedures. In addition, the on-call consultant in Drogheda expressed no knowledge of Cavan/Monaghan Hospital inadequacies.
- 1.8 The reviewers recommend most strongly that this is an opportunity for all the relevant stakeholders to pause and ensure a clear refocusing on the core values of patient care. The inquiry has revealed evidence that continued disputes of an inter-personal and "political" nature have resulted in a loss of this basic perspective.
- 1.9 The reviewers believe that there has been continued failure on the part of management over a sustained period of time to address the factors resulting in

the failure of Mr. Walsh's hospital transfer. For patients in Monaghan Hospital who required acute surgical care, there was no clear pathway to achieve "appropriate transfer status".

- 1.10** The reviewers further believe that management steps, in relation to patient transfer, taken to reduce risk since the death of Mr. Walsh were not initially effective. (However, at the time of report completion, the most current transfer protocols now dictate that Cavan Hospital has an absolute obligation to receive such transfers from Monaghan Hospital).
- 1.11** The review revealed systematic evidence of lack of engagement between management and clinicians that has made a major contribution to the circumstances resulting in the death of Mr. Walsh.
- 1.12** It is therefore recommended that a major reassessment of management structures and process be undertaken to ensure effective manager/clinician engagement and future collaboration.
- 1.13** It is however emphasised that the prime responsibility for this development lies with hospital management at both local and regional level.
- 1.14** The reviewers believe that the decision to appoint a Lead Surgeon independent of the Director of Surgical Affairs, Royal College of Surgeons in Ireland (RCSI), while well intentioned, was ill judged and has proved to be less effective than anticipated.
- 1.15** The reviewers believe that the development of a programme of Clinical Governance should be introduced to all linked hospitals as a matter of urgency.
- 1.16** The reviewers further believe that the RCSI has a clear responsibility of surgical leadership in these issues and should work more actively and more closely in collaboration with both surgeons and administration/management alike.
- 1.17** The reviewers believe that in relation to surgical matters this process should be developed in collaboration with the Director of Surgical Affairs (RCSI) where the responsibility for surgical standards lies.
- 1.18** The reviewers believe that the clinical staff, in Monaghan Hospital, has been exposed in an unacceptable manner to continued risk and potential criticism.
- 1.19** As part of the risk reduction process it is recommended that all acute in-patient services at Monaghan Hospital be suspended as soon as is practically possible. This move would definitively remove the risk of a similar clinical incident occurring again.

- 1.20** The reviewers recognise that in order for this to happen it is essential that resources be provided to both Cavan and OLOL Hospitals, to expand their in-patient capacity. Immediate consideration should be given to the undoubted pressures a closure of in-patient facilities at Monaghan Hospital would cause in the neighbouring hospitals and thus an urgent, rapid programme of resource expansion is required for Cavan and OLOL. In the early phases of this process, this may involve temporary collaboration with other hospitals inside and outside the region.
- 1.21** It is further recommended that the Treatment Room at Monaghan Hospital be reconfigured to become a nurse-led minor injuries unit, offering patient treatment during normal “office” hours only.
- 1.22** The continuing uncertainty regarding the future configuration of clinical services at Monaghan Hospital should be resolved most urgently. One potential option (see section 10 below) could be the establishment of a ***newly resourced*** Diagnostic and Treatment Centre. Such a new centre could provide a full range of ambulatory care facilities including day surgery, endoscopy and physiotherapy. In addition state of the art imaging facilities including cross sectional imaging could be developed within this new health care facility.
- 1.23** The reviewers believe that if these recommendations are implemented this will result in the development of a health care facility that could significantly improve the quality of patient care in the area, as well as developing a more positive professional atmosphere to facilitate future, more extensive reforms.

## **2 Introduction**

**2.1** Following the death, in Monaghan Hospital, of Mr. Walsh in circumstances which gave rise to concern and quickly entered the public domain, Mr. Pat McLaughlin the then CEO of the Health Service Executive, Hospitals Network, commissioned an independent private report.

**2.2** The original remit, as outlined in an initial draft Terms of Reference, allowed for an investigation and assessment of the critical facts and was to be centred on the narrow time frame from the transfer of Mr. Walsh from Our Lady of Lourdes Hospital, Drogheda until death. This period was approximately sixteen hours. However, it was immediately apparent that restricting the review to this short time frame would ignore very significant factors immediately preceding Mr. Walsh's transfer to Monaghan Hospital, which had an impact on the eventual outcome. The original remit, while concentrating on the clinical circumstances, would also ignore a multitude of administrative and management factors which potentially contributed to Mr. Walsh's ultimate demise. It is pertinent that in the background in which this death occurred there were a number of clinical incidents already recorded in the public domain. Thus, the Minister for Health and Children, in discussions with Mr. Walsh's family and through the office of the HSE Hospitals Network, with the independent investigators accepted the need for a more extensive inquiry. This inquiry would also consider factors other than clinical ones which may have directly or indirectly impacted on the clinical care received by Mr. Walsh (Appendix 1).

**2.3** As the remit of the inquiry had therefore been extended to include significant work beyond an investigation of a single critical incident, it was recognized that this task was unrealistic for a single investigator. Mr. Declan Carey, who was nominated by the Royal College of Surgeons in Ireland to conduct the original limited review, invited Professor John Monson, Professor of Surgery, University of Hull to join the inquiry team. The nature of the review was to be a private, independent non-statutory inquiry.

**2.4** The inquiry was commissioned on 18<sup>th</sup> October 2005, with Professor Monson's involvement confirmed on 31st October, 2005.

The reviewers wish to acknowledge the huge loss that the death of Pat Joe Walsh has brought to the circle of this close-knit County Monaghan family. The reviewers

also wish to acknowledge that the very public reporting of the death of Mr. Walsh and the tragic circumstances in which it occurred, may have created an abnormal grieving process. It is the sincere hope of the review team that the inquiry has been sufficiently thorough and accurate to go a long way to answering the family's questions regarding Mr Walsh's death.

### **3 Methodology Employed**

- 3.1** This investigation proper commenced in mid December, 2005. In the six weeks prior to this, discussions with relevant parties led to agreement of the Terms of Reference (Appendix 1). These were finally signed off by the National Hospitals Office of the Health Service Executive before Christmas 2005. On initial examination of the clinical notes relating to Mr. Walsh's care in Our Lady of Lourdes Hospital, Drogheda and Monaghan Hospital, it was apparent that the factors which may have led or contributed to the patient's death were by and large outside the sphere of clinical management. It was felt by the reviewers that the standard techniques for the examination of a critical clinical incident may not be fully appropriate if applied to this investigation. Thus, it was concluded that the investigation should be carried out using the Principles of Qualitative Research. However, during the conduct of the investigation, the principles outlined in "A Protocol for the Investigation and Analysis of Clinical Incidents" as published in September 1999 (Clinical Risk Unit, University College London and Association of Litigation and Risk Managers, Royal Society of Medicine) were also employed.
- 3.2** The initial step was the review of the clinical notes, which allowed identification of the problem areas and establishment of the list of potential interviewees (Appendix 3a & 3b). All documentation subsequently requested by the reviewers and made available to them is included in Appendix 4. In addition, a wide range of relevant historical documents and reports relating to either clinical events or policy development was also made available to the reviewers for information (Appendix 4).
- 3.3** When the chronology of events was established, care management problems identified and contributory factors, both specific and general, were clarified, the interviews were conducted according to structured guidelines (Appendix 2).
- 3.4 Principles of conduct of interviews:**  
Interviews were undertaken in private, away from place of work, and in a relaxed setting following a semi-structured format. The two reviewers jointly conducted each interview. Recording was accomplished by transcription, using professional stenographers, and a printed hard copy was produced for each interviewer to facilitate subsequent analysis of the material collected. Transcripts were also saved to CD ROM for each investigator. All interviewees were invited to nominate

an accompanying person should they wish to do so. Each interviewee was invited to submit a written statement in advance of interview; this was not, however, a compulsory part of the interview process. Each medical and nursing interviewee was afforded the opportunity of legal advice prior to submitting statements, if wished.

- 3.5** The investigation commenced with a private meeting between the investigators and a large number of immediate relatives of Mr. Walsh, which took place in the Nuremore Hotel in Carrickmacross on 16th November 2005. At this meeting, the family was encouraged to discuss all their concerns regarding the clinical care received by Mr. Walsh and any non clinical factors that they felt to be of importance. The family was also given the opportunity to review the Draft Terms of Reference and Guidelines for Conduct of the Inquiry. This meeting was to facilitate a wish expressed by Mr Walsh's family in a meeting with the Tánaiste 27<sup>th</sup> October (Appendix 5a). Thereafter, family members were interviewed and treated, as were all other interviewees, as per inquiry guidelines (Appendix 2). A series of interview days was timetabled and scheduled with the assistance of the administrative staff from the HSE North East, Hospital Network Manager's Office. These took place between January and March 2006. Nursing staff were all subsequently accompanied by an officer of the Irish Nurses Organisation.
- 3.6** As noted above, the reviewers were provided with a wide ranging list of documents/reports relating to the administration and delivery of health care in the Cavan/Monaghan region and the North Eastern Health Board region dating back to 1991. A reading of these documents allowed identification of the relevant personnel, from management and health service administration, who were felt by the reviewers to be of assistance to the inquiry (These documents are listed in Appendix 4 as are all of the documents requested and provided to the reviewers).
- 3.7** In addition the reviewers undertook a site visit to Monaghan Hospital, 17<sup>th</sup> January 2006, where a visit to all relevant clinical areas was facilitated.

### 3.8 Analytic Method

The interviews were, as noted above, transcribed and each interview outline was considered and analysed for the data thus produced.

The analysis of the events continued using the principles of Qualitative Research.

### 3.9 *“Qualitative Research is concerned with the meanings people attach to their experiences of the social world and how people make sense of that world. It therefore tries to interpret social phenomena (interactions, behaviours, etc) in terms of meanings people bring to them”.*

**Pope and Mays (2000) Qualitative Research in Health Care, BMJ Publishing Group).**

### 3.10 The ‘a priori’ issue in this instance is; What caused the death of Mr. Walsh?

The interviews were two to one, semi-structured interviews and the analysis was conducted by Thematic Analysis using a Framework approach. The Framework approach is that as described by **Richie and Spencer 1994; Analysing Qualitative Data**. Using this tool investigators familiarise themselves with the data, go through a process of identification of themes and the subsequent coding of those themes and sub themes. Charting of themes then occurs and finally mapping and interpretation is conducted. The sample size for such research is dictated by the Principle of Recruitment to Saturation. Usual sample size is of the order of 10-15 people/interviewees. Thus the sample size in this investigation exceeded the size required.

### 3.11 The analysis and interpretation of the data and report writing were conducted in meetings subsequent to the interviews. In the interests of fair processes and procedures the reviewers also sought comments from individuals named or alluded to in a preliminary version of this report. Following completion of the preliminary report the individuals listed in Appendix 6 (list A) were sent relevant copies of extracts from the preliminary report and asked to respond. The reviewers have carefully considered all responses received.

### 3.12 The reviewers wish to acknowledge the contribution made by Ms Irene O’ Hanlon, Risk Advisor, Louth/Meath Hospital Group to the conduct of this inquiry. The reviewers were given unrestricted access to all requested documentation and full co-operation was forthcoming from all those invited to interview or to submit written statements.

## **4 History and Chronology of Case**

### **4.1 Introduction**

**4.1.1** This section of the review will summarise the history and clinical care of Mr Walsh during his stay in Our Lady of Lourdes Hospital, Drogheda and subsequently following his transfer to Monaghan Hospital. The summary has been compiled following examination of a series of photocopied medical records supplemented by interview material from family, nursing and medical staff. The reviewers satisfied themselves that they were supplied with all relevant clinical material (Appendix 4).

### **4.2 Clinical History**

**4.2.1** On 21 09 2005 Mr Walsh was found at home by a member of his family after he had fallen and injured his hip. He was, then, taken by car to the A&E department of Our Lady of Lourdes Hospital, Drogheda, by his family.

**4.2.2** According to the medical records he was admitted to hospital at 04.30 hours. A detailed handwritten clinical note appears in the record. It is noted that there was limited information available in relation to Mr Walsh's previous medical history and that his general practitioner would be contacted to clarify what medications he had been taking on a long term basis (subsequently clarified he was taking no long term medication). Initial investigations revealed that Mr Walsh had suffered a sub capital fracture of his right hip. Apart from being a little hard of hearing, he was considered to be otherwise well and plans were put in place to take him to theatre for a right hemi-arthroplasty (a partial hip replacement undertaken for fractures). Mr Walsh signed the appropriate consent form prior to his surgery.

**4.2.3** Originally the plan had been for Mr Walsh to be taken to the operating theatre later that same day but for logistic reasons (time constraints) his surgery was postponed.

**4.2.4** At 12.00 hours on 21 09 2005 there is the first indication in the medical record that Mr Walsh was suffering from a degree of confusion and agitation. According to the record, he was trying to get out of bed and did not realise that he had broken his hip. The main theme of the written notes, for the next 48 hours in hospital was an attempt to determine the cause of this agitation and confusion. There was a suggestion that this problem might be due to some form of infection as the white cell count was noted to be elevated at 17.9. In addition, the patient had some

evidence of poor air entry on chest examination.

- 4.2.5** On 23 09 2005 the patient was seen, in consultation, by the medical service with a view to identifying a cause for his confusion. As per record, re the assessment at 15.30 hours, the patient remained confused and agitated and clinical examination did not reveal any obvious source of infection. The conclusion drawn was that the confusion might well be due to an infective process, the most likely source being a urinary tract infection. Various investigations were undertaken including arterial blood gas measurements and blood cultures. A chest x-ray was also requested.
- 4.2.6** Later that same day (at 18.00 hours), the patient was taken to the operating theatre and had a right hemi-arthroplasty carried out by Mr Reidy, consultant orthopaedic surgeon. The operation was entirely standard in its approach and completion and was undertaken without intra-operative complication.
- 4.2.7** Over the next few days, the patient's recovery was slow and difficult, largely as a result of his ongoing confusion and agitation. He sustained a fall and minor laceration on 26 09 2005 and the following day underwent a CT scan of his head. This revealed evidence of mild diffuse atrophy of the cerebral cortex consistent with his age and possible early dementia.
- 4.2.8** By 29 09 2005 consideration was being given to transferring the patient to Monaghan Hospital for further rehabilitation and convalescence. However, this was delayed because of his confusion and in order to clarify the results of the blood cultures (clear of infection).
- 4.2.9** On 30 09 2005 the patient's condition changed markedly when he became hypotensive, tachycardiac and tachypnoeic. His preoperative blood pressure had been approximately 140/70 mmHg and this had now fallen to 90/50 mmHg with an associated rise in pulse rate to 100 beats per minute. An initial clinical assessment suggested the possibility of a myocardial infarction or pulmonary embolus but consideration was also given to the possibility of a gastrointestinal haemorrhage. The patient was commenced on intravenous antibiotics including Gentamicin, Cefuroxime and Metronidazole. A urinary catheter was inserted to monitor renal function and a general surgical review was requested.
- 4.2.10** With the aid of some intravenous fluid resuscitation, the patient's blood pressure increased to 124/50 mmHg but his haemoglobin was noted to have fallen to 10.1 g/dl in keeping with the diagnostic possibility of a gastrointestinal haemorrhage. Over the next 48 hours the patient remained stable and was taken for an upper

gastrointestinal endoscopy. This was performed on 04 10 2005 by Mr J McGrath, consultant surgeon. His handwritten endoscopy record appears in the notes and confirms the presence of an actively bleeding duodenal ulcer. Endoscopy findings included considerable amounts of blood in the duodenum and stomach and extensive lavage was undertaken to clear this away. Clot adhering to the ulcer base was identified and the ulcer itself was injected with 6 mls of "1 in 10,000 Adrenaline." The bleeding was controlled and the patient was then commenced on an intravenous infusion of a proton pump inhibitor and placed under close observation. Repeat endoscopy was recommended for the following day.

- 4.2.11** Mr McGrath also spoke to Mr El-Masry, consultant gastrointestinal and general surgeon, to ensure that the patient was followed up by the appropriate surgical team (Mr Walsh at that time was under the care of the Orthopaedic Surgical team).
- 4.2.12** On 05 10 2005 the patient underwent a repeat upper gastrointestinal endoscopy and on this occasion the procedure was performed by a surgical specialist registrar. The findings were of a large deep ulcer in the first part of the duodenum with a large clot. There was no active bleeding identified. A further injection of "8 mls of 1 in 10,000 Adrenaline" was undertaken.
- 4.2.13** Both endoscopies occurred without difficulty or complication. The patient then proceeded to make a satisfactory recovery from this episode over the next few days. His haemoglobin was checked on a number of occasions and found to be stable and he had no further evidence of gastrointestinal haemorrhage. On 07 10 2005 he was seen by Mr El-Masry who recommended that he should commence "triple therapy" for his duodenal ulcer and could also begin eating a light diet. This joint care between the orthopaedic and general surgical service continued for a number of days and ultimately it was decided that Mr Walsh could indeed be transferred to Monaghan Hospital.
- 4.2.14** Originally, the plan had been for him to be transferred to Monaghan Hospital on 12 10 2005. However, for reasons of logistics and bed availability this transfer did not take place until 13 10 2005.

### **4.3 Clinical Course in Monaghan General Hospital**

- 4.3.1** Prior to Mr Walsh's transfer to Monaghan Hospital a handwritten discharge summary was provided from Our Lady of Lourdes Hospital. This appears in the Monaghan Hospital records and included the relevant history of hip fracture, subsequent surgery and the details in relation to the endoscopy and bleeding duodenal ulcer. The transfer documents also include details of medications and levels of mobility. This included a summary from the physiotherapy and rehabilitation department re the degree of mobility Mr Walsh had achieved since his surgery.
- 4.3.2** As per the nursing records, the patient arrived in the surgical ward at 16.30 hours and was assessed and admitted by the surgical SHO later that evening. The admitting doctor compiled a detailed medical record timed at 21.00 hours at which point the patient was stable. His blood pressure was 170/84 mmHg and the patient was noted to be still somewhat mildly confused. Arrangements were made for the patient to continue his rehabilitation in collaboration with the physiotherapy department.
- 4.3.3** At 23.20 hours (as per the nursing records) the patient was noted to be clammy and sweaty. His blood pressure had dropped to 95/64 mmHg and his pulse rate had risen to 145 beats per minute. The surgical SHO was called to see the patient. The medical records are timed at 12 midnight and confirm the history of sweating and hypotension. The patient was described as being unresponsive for a brief period of time and his blood pressure was now 70/45 mmHg with a pulse rate elevated at 140 beats per minute. An urgent ECG was carried out and was non contributory. A clinical diagnosis of either a cardiac event or pulmonary embolus was made and immediate resuscitative measures were taken addressing issues such as airway and circulation. Routine blood tests were sent off as an emergency. The cardiac arrest bleep was used to obtain additional assistance from the anaesthetic staff. Blood was grouped and cross matched in view of the possibility of a further gastrointestinal haemorrhage and at 00.40 hours the patient was transferred to the special care unit for further resuscitation. The second on-call surgical doctor, Mr Jha (surgical registrar), was informed and he came to see the patient. At 01.30 hours the patient had a large haematemesis of approximately 1000 mls of fresh blood. By this time he was already receiving a blood transfusion

and attempts had been made to transfer the patient to another hospital.

Mr Cazabon (consultant surgeon) was informed about the patient. He also now came in from home to see the patient.

- 4.3.4** In the early hours of 14 10 2005 there is a detailed handwritten clinical note from Mr Jha. This note is untimed. Essentially, this record details the sequence of events that occurred since the patient was admitted from Drogheda. This record includes the details of Mr Jha's attempts to transfer the patient to another acute hospital in view of the diagnosis of a recurrent duodenal haemorrhage.
- 4.3.5** The medical notes state that he contacted Drogheda Hospital (at 1.03am from hospital telephone record) but they "would not accept" (Mr El-Masry was the on-call consultant). In the next line he states "contacted Cavan – no ICU bed therefore, cannot accept." (at 1.16am from hospital telephone record). The next note states "contacted Beaumont Hospital – no ICU bed available", (at 1.30am from telephone record), "Mr Cazabon informed". This note also includes the statement that Mr Jha spoke to the patient's family and made them aware of the situation in terms of the difficulties of transfer. The record also details that the family was kept apprised of the situation regularly by various members of the Monaghan medical and nursing staff.
- 4.3.6** According to the anaesthetic notes dated 13 10 2005, the patient had undergone aggressive attempts at resuscitation by the staff present. Venous access was obtained using intravenous cannulae inserted in the right internal jugular vein, left internal jugular vein, right and left forearms. The patient received intravenous infusions of packed red cells (blood), Voluven (a volume expander) and Hartmann's solution (a crystalloid intravenous fluid).
- 4.3.7** Over the next few hours the patient's situation and clinical status gradually deteriorated. According to the records, multiple discussions were had with the family and it was decided that although resuscitation should be continued, the patient would not be for intubation (a pre-cursor to assisted ventilation) should this be required. According to the records – both nursing and medical – the patient ultimately became bradycardic and unresponsive before asystole developed and the patient was pronounced dead at 07.15 hours. His family was in attendance at the time of his death.

**4.3.8** The medical staff contacted the Coroner for advice concerning a post mortem examination. However, the Coroner determined that this would not be required and that Mr Walsh's remains could be released to the family.

#### **4.4 Reviewers' Comments in Relation on Clinical History and Care**

**4.4.1** The reviewers believe that the management of the patient while in Our Lady of Lourdes Hospital, Drogheda was appropriate and timely. There was no evidence of substandard care.

**4.4.2** Mr Walsh was admitted, like many men of his age, with a fracture to his hip following a fall. Fairly shortly after his admission to hospital he became confused and agitated. This is by no means an unusual phenomenon in elderly patients who have suffered a sudden and serious trauma requiring admission to hospital. However, there was also evidence to suggest that the patient might have some underlying infection as an additional cause of his confusion and, therefore, appropriate investigations were undertaken with this in mind.

**4.4.3** The patient's initial operation was postponed because of time constraints but ultimately he underwent a successful hemi-arthroplasty carried out by a consultant surgeon. The operation was performed in a standard manner without any complications. Over the next few days the patient's rehabilitation progressed but he developed a bleeding duodenal ulcer. This is a relatively common occurrence following major surgery and the patient received both timely and appropriate endoscopic therapy.

**4.4.4** The endoscopy carried out by Mr McGrath revealed evidence of significant bleeding from a duodenal ulcer and this was dealt with both expertly and successfully by the injection of Adrenaline.

**4.4.5** Mr McGrath's documentation is detailed and appropriate as was his decision to speak to Mr El-Masry regarding ongoing care. Mr El-Masry was locally based in Drogheda, unlike Mr McGrath, who is a visiting surgeon from Navan Hospital, and therefore this was a sensible step.

**4.4.6** The next day the patient underwent a further endoscopy for review of his duodenal ulcer. The ulcer had now stopped bleeding and a further injection was undertaken.

**4.4.7** Over the next 8 days the patient remained completely stable during his ongoing

rehabilitation and showed no evidence of further gastrointestinal haemorrhage. He was seen by both the general surgical and the orthopaedic surgical service and commenced on the appropriate management (triple therapy) and was back on a normal diet prior to his transfer to Monaghan Hospital.

**4.4.8** It is, therefore, the opinion of the reviewers that the decision to transfer the patient to Monaghan Hospital in terms of his duodenal ulcer status was perfectly reasonable and appropriate. In fact, the reviewers believe that had the patient's mobility permitted such a thing, it would have been appropriate to discharge him home.

**4.4.9** *It is the reviewers' opinion, therefore, that the patient's management while in Our Lady of Lourdes Hospital was acceptable and beyond criticism.*

**4.4.10** The patient then arrived at Monaghan General Hospital and was seen on admission by both the nursing and medical staff. Although the patient remained slightly confused, it was clear that he was haemodynamically stable and essentially unchanged from the time of his departure from Our Lady of Lourdes Hospital.

**4.4.11** Within a few hours, however, the patient's clinical status changed dramatically and he became shocked with evidence of hypotension and bleeding. It was very quickly apparent to the medical staff that the most likely diagnosis was a recurrent haemorrhage from his duodenal ulcer.

**4.4.12** *The reviewers believe that the process of resuscitation undertaken by the team involved (surgical, medical, anaesthetic and nursing) was appropriate and adhered to international standards and guidelines.*

**4.4.13** The relevant surgical registrar recognised that the patient needed to be transferred to an acute hospital capable of undertaking surgery at this time. This patient was haemodynamically unstable and would almost certainly need to be taken to an operating theatre for definitive surgical intervention. This was not possible in Monaghan Hospital due to lack of facilities and, therefore, urgent transfer was required. The question of performing further endoscopic management did not arise as the doctors in Monaghan felt they were under the same constraints for endoscopy as for emergency surgery (i.e. no endoscopic facilities available after hours). The reviewers agree that attempts to undertake therapeutic endoscopy without appropriate technical support would have been inappropriate, practically impossible without such support and may have further

jeopardized Mr. Walsh. Immediate transfer remained the required action.

- 4.4.14** Quite appropriately, in the reviewers' opinion, the registrar initially contacted Drogheda as the patient had only just arrived from there a few hours before. As per the medical records, the consultant surgeon on-call in Drogheda, Mr El-Masry, declined, on this initial contact, to take the patient back and recommended that the patient be resuscitated adequately and Cavan be contacted as this was nearer and the affiliated institution to Monaghan Hospital. According to the interviews held by the reviewers, the surgical registrar in Monaghan (Mr Jha) did not speak to Mr El-Masry personally but made contact with and through the surgical registrar (Appendix 3) on-call in OLOL Hospital. Mr Jha was quite clear in his statement that he informed Drogheda that Mr Walsh was the patient who had suffered a duodenal haemorrhage while in Drogheda and had only just been transferred to Monaghan.

***The reviewers believe that it is likely that Mr Jha would have informed Drogheda of this sequence of events.***

- 4.4.15** In contrast, Mr El-Masry stated during interview that he was unaware that the request for transfer related to the same Mr Walsh whom he had seen and who was discharged the previous day. In addition, the surgical registrar on-call that night in Drogheda stated, at interview, that he had not been informed by Mr Jha that the patient in question had been the same Mr Walsh who required emergency treatment for a bleeding duodenal ulcer in OLOL Hospital. However he did recognise, in a written submission to the reviewers, that he was informed that the patient had been transferred from the Orthopaedic Dept. in OLOL Hospital.

***The reviewers note that there are two significantly differing accounts and a clear difference of opinion as to the content of the same telephone communications.***

Both parties acknowledge that the request for transfer concerned the transfer of a critically ill patient and the issue of the type of bed (general or ICU) was not discussed. Nursing staff interviewed, from Drogheda (Appendix 3), confirmed they were not contacted to establish whether an ICU bed was available or not. The documentation provided to the reviewers by OLOL hospital does confirm that a single ICU bed was available at the time the request came from Monaghan for Mr Walsh's transfer.

As a consequence of the perceived refusal of Drogheda to accept the patient, Mr

- 4.4.16** Jha then phoned Cavan Hospital with the request for transfer. He spoke to the surgical registrar on-call (Appendix 3) and was subsequently called back and told there were no ICU beds available. Therefore, the patient could not be accepted. The Monaghan surgical registrar stated at interview that the reason for refusal of transfer to Cavan Hospital had been given as unavailability of an ICU bed. This was confirmed at interview by the on-call registrar in Cavan Hospital who stated that Mr. Mc Murray advised him that there were no ICU beds available in Cavan Hospital and therefore not to accept transfer of the patient.
- 4.4.17** As a result of this failure to achieve transfer of the patient, Mr Jha then phoned Beaumont Hospital (Dublin) and received the same response – that there were no ICU beds available, therefore, the patient could not be accepted (Appendix 4).
- 4.4.18** The reviewers interviewed the nurse manager/night superintendent (Appendix 3) on-call in Cavan at the relevant time. This nurse was responsible for bed management during that period of time and would have expected to have been called if there was a need for an ICU bed. She stated to the reviewers that she was never called. In addition, she also confirmed that at the relevant time there were ICU beds (2) available in Cavan (confirmed by bed management figures submitted by CGH, Appendix 4).
- 4.4.19** The reviewers also spoke with Mr McMurray, consultant surgeon, at Cavan General Hospital on the relevant night. Mr McMurray confirmed at interview that he had been asked by the relevant surgical registrar on-call in Cavan Hospital whether or not he should accept the patient from Monaghan. Mr McMurray stated at interview that he had declined to take the patient, not because of the lack of an ICU bed but, because he was working under an operational policy and guideline that precluded him undertaking such major emergency gastrointestinal surgery. Mr McMurray provided documentary evidence to support his contention that such a policy was in operation at the time (Appendix 5b&5c). This document was not originally furnished to the reviewers at the commencement of the inquiry.
- The relevant operational policy and guideline was not furnished to the reviewers by the HSE North East at the commencement of the inquiry. It was only made available late in the course of the inquiry – firstly, by Mr Finbar Lennon at interview on 2<sup>nd</sup> February 2006, and secondly, in Mr Mc Murray's written submission furnished prior to interview and dated March 2006. According to Mr. McMurray, this operational policy and guideline was***

***critical to his decision not to accept the late Mr Walsh into his care. The reviewers remain unclear why the operational policy and guideline were not included in the original file of documentation prepared for them by the HSE North East before commencement of the inquiry.***

**4.4.20** It was suggested to the reviewers (by witnesses other than Mr. McMurray) that the statement that there were no ICU beds available was simply a euphemism for declining to take the patient for other reasons.

**4.4.21** ***The reviewers believe that there are clear discrepancies and differences in interpretations, relating to process and policy, in the account of events described by these witnesses.***

**4.4.22** The reviewers also spoke to Mr Cazabon, consultant general surgeon, in Monaghan who was responsible for the care of Mr Walsh during his admission. The reviewers asked Mr Cazabon if he had considered calling either hospital personally to overturn the decision. Mr Cazabon said that he had not considered making personal calls and wasn't really able to say why this was the case. However he stated: ***"...unless the man was stable enough and then I would obviously have rung for a transfer."*** A similar point was made by Mr Cazabon regarding the question of putting Mr Walsh in an ambulance and transferring him to Cavan or Drogheda without consent from the receiving Hospital.

**4.4.23** It should be noted that while the doctors and nurses in Monaghan were involved in the care of Mr Walsh, there was another patient in the hospital at that time who had been admitted with suspected appendicitis. According to the surgical transfer guidelines in place at the time, that patient would normally have been transferred to Cavan for possible appendicectomy. Due to the pressure on general beds in Cavan a request had been made to keep the patient in Monaghan overnight until he could be moved the following day. The Monaghan doctors were told that if the patient's condition should deteriorate during the night then they should contact Cavan again and transfer would be arranged.

**4.4.24** The evidence from the documentation and witness statements confirms that the patient's condition did deteriorate and he developed increasing pain. Consequently, through a process that involved bed managers in both Monaghan and Cavan and the junior doctors, the patient was transferred in the early hours of the morning (14<sup>th</sup> Oct), to CGH at 4.30 am. This process occurred at the same time that resuscitative attempts to save Mr Walsh's life were taking place.

- 4.4.25** *The reviewers found this sequence of events surprising and barely credible and felt that such a situation was incompatible with appropriate clinical practice.*
- 4.4.26** The reviewers wish to comment on the role and actions of the consultant surgeons involved in this case. The first consultant to be contacted re Mr Walsh's case was Mr El-Masry in Drogheda. The reviewers believe that on the balance of probability, it is more than likely that the surgical registrar on-call (and possibly Mr El-Masry) was informed that the transfer request related to a patient who had been treated for a bleeding duodenal ulcer in Drogheda and had just been transferred to Monaghan. This, in fact, was the basis for first calling Drogheda and the reviewers find it hard to accept that this information was not made clear during the telephone discussions. ***Regardless of the above contention, the reviewers believe that Drogheda hospital staff, while having no legal obligation to do so, had a clinical responsibility to take Mr Walsh back without hesitation, particularly in the light of the known restrictions placed on the surgical staff in Cavan/Monaghan.***
- 4.4.27** The next consultant to be contacted about Mr Walsh was Mr McMurray (the on-call surgeon at Cavan Hospital). At this time, Mr McMurray knew that a transfer from Monaghan to Drogheda had been declined and, therefore, the situation was now most urgent. There is no suggestion that Mr McMurray was not aware of the nature of the case and the seriousness of the patient's status.
- 4.4.28** ***While the reviewers accept Mr McMurray's statement as to the policy that was in operation at that time, they are not clear that his refusal to accept the patient was solely on this basis. It is noted that the policy referred to by Mr. McMurray relates to undertaking major elective and emergency gastrointestinal surgery (Appendix 5b). However this information was not conveyed to the Monaghan doctors in the relevant telephone calls at the time they were seeking transfer of Mr Walsh. If this was the sole reason for Mr. McMurray's decision regarding transfer, it is not clear why he did not state this explicitly at the time. It is also not clear to the reviewers why the surgical/medical staff in OLOL seemed unaware of this policy. Clearly had there been widespread ownership of this policy then the suggestion of seeking a transfer to Cavan would not have been made.***
- 4.4.29** The reviewers believe that Mr McMurray would have been able to determine that

there were indeed intensive care beds available in Cavan and it was, therefore, inappropriate for surgical staff to use lack of such facilities as an excuse.

**4.4.30** The third consultant surgeon involved in Mr Walsh's care was Mr Cazabon. Mr Cazabon was involved and aware of relevant issues during the critical phases of these events, that is, during the latter phases of the resuscitation and immediately following the attempts to obtain transfer to another hospital. The reviewers were most surprised that a consultant surgeon of Mr Cazabon's seniority did not feel it appropriate to call either Mr El-Masry or Mr McMurray personally and insist that the patient be transferred. ***The reviewers feel that while Mr Cazabon had no legal obligation to undertake such a call, best practice would dictate that he make every effort to obtain a successful transfer of the patient.***

Similarly, the reviewers are surprised that Mr. Cazabon made no attempt to initiate a direct transfer of Mr. Walsh, by ambulance, to either Cavan or Drogheda despite the reluctance of the receiving hospitals.

***Once again the reviewers are not clear why Mr. Cazabon (or indeed any other staff within Monaghan hospital) were unaware of the operational policy pertaining to surgical restrictions at Cavan which is part of the same institution. At best this reflects extraordinarily poor organisational communication within Cavan/Monaghan Hospital and in the region as a whole.***

**4.4.31** The reviewers have given careful consideration to the argument that the Monaghan Medical Staff should have broken the protocol of "stabilise and transfer", and made an attempt to treat endoscopically or indeed, operate on Mr Walsh. However, such interventions require a multidisciplinary team with technological resources accessible and immediately operational. This was not the case in Monaghan Hospital on the night in question. ***The reviewers do not believe therefore, that the intuitive argument of breaking protocol and treating Mr Walsh in Monaghan was realistic. The reviewers do believe that the attempted option of transferring him to a facility which had the necessary resources was the appropriate and required course of action.***

**4.4.32** In relation to the communication with Beaumont Hospital, the reviewers felt that this was the least important contact in the time period. Inquiries revealed that although a single ICU bed ultimately became available on the night in question, at the time the request from Monaghan was made, all general and neurosurgical ICU

beds were committed. In other words, there was no bed available.

**4.4.33** In summary, in relation to the patient's management and care, the reviewers believe that there is no evidence to suggest that the patient was subjected to substandard or negligent treatment. The reviewers also note that at the time of Mr Walsh's collapse in Monaghan Hospital due to recurrent bleeding from his duodenal ulcer, the chance of him surviving subsequent surgery even if he had been successfully transferred to either Drogheda or Cavan would not be high. ***Nonetheless, the reviewers believe that failure to successfully transfer the patient to one of these two affiliated hospitals was quite unacceptable even if the patient had died during transfer or subsequent surgery.***

**4.4.34** The reviewers believe that these events occurred not primarily as a result of individual clinician failures, but as a consequence of dysfunctional processes, relationships and management structures. ***The reviewers believe that the professional failings in this case are, significantly interlinked to, and are in large part a consequence of deficiencies in other areas.***

## **5 Clinical Issues in Our Lady of Lourdes Hospital**

**5.1** The chronology of the case history arises from the initial management of Mr. Walsh in Our Lady of Lourdes Hospital where his hip surgery was performed. Although Mr. Walsh ultimately died from recurrent haemorrhage from duodenal ulceration the primary treatment for this postoperative complication had taken place entirely in Drogheda. While the clinical details have been recounted in the preceding section as is the reviewer's critique, the reviewers felt that it would be useful to consider this phase of the patient's management again to specifically address the question as to the advisability of Mr. Walsh's transfer to Monaghan in the first instance.

### **5.2 Standard of Care for Bleeding Duodenal Ulcer**

**5.2.1** In this review, the issue of safety of Mr Walsh's discharge from Our Lady of Lourdes Hospital, Drogheda to Monaghan Hospital, a facility where emergency surgery was not available, has been raised. This question relates to the evaluation of the risk of a further bleed from Mr Walsh's already proven duodenal ulcer (DU).

**5.2.2** The initial treatment for the DU on 4<sup>th</sup> October while still an in-patient, was by endoscopy and injection therapy using adrenaline. This is "standard of care" and the first line treatment for bleeding ulcers of this type. It is clear from review of the clinical notes and past medical history that Mr Walsh had no known history of peptic ulcer disease and on admission following treatment of his hip fracture, was not on any medication relating to gastric or duodenal disease. In particular, he was not currently taking a proton pump inhibitor, a class of drug which is most commonly used to treat ulcer disease.

**5.2.3** In the days preceding 4<sup>th</sup> October 2005, Mr Walsh became unwell and was repeatedly assessed by medical, surgical and orthopaedic staff in the Orthopaedic Unit. A presumptive diagnosis of a bleeding ulcer was made. This became evident when Mr Walsh subsequently passed melaena (black tarry stool indicative of bleeding from the gastrointestinal tract). The procedure to diagnose this condition, a diagnostic endoscopy (flexible fiberoptic endoscope is passed through the mouth into the duodenum), was performed on the 4<sup>th</sup> October 2005, following the standard preparation. Mr Walsh was demonstrated to have an actively bleeding, large ulcer in his duodenum. The treatment applied was an injection of 6mls of "1 in 10,000 adrenaline." This procedure appeared during observation to control the

bleeding. The endoscopist, however, was sufficiently concerned about his findings to document these in a letter and make a personal phone call to the Consultant Surgeon responsible for Mr. Walsh's care. In this communication it was recommended that Mr Walsh should have a repeat endoscopy within a short period of time. The purpose of this was to ascertain the continued stability of the ulcer and in particular to ascertain that there was no ongoing bleeding. This approach to actively bleeding DUs is supported widely in the medical literature, where it has been shown conclusively, that a scheduled second endoscopy 16–24 hours after initial endoscopic haemostasis (control of bleeding) reduces recurrent bleeding and also the incidence of requirement for open surgery. The second endoscopy took place on 5<sup>th</sup> October 2005, and again the large deep ulcer in the first part of the duodenum was clearly identified with some adherent clot but no active bleeding. As per standard treatment, further injection therapy with adrenaline was undertaken. Mr Walsh's subsequent clinical course was stable from the point of view of his haemorrhaging ulcer. There is no evidence up to and including the discharge on 13<sup>th</sup> October 2005, to Monaghan Hospital, that there was re-activation or continued bleeding from his ulcer.

**5.2.4** In assessing the risk of re-bleeding and the absolute requirement for a surgical approach to treat a bleeding DU there are standard National and International Guidelines which can be applied. Though not formally applied by the medical staff managing Mr Walsh, it is evident from the clinical documentation that the standard of care reached and exceeded National and International guidelines.

**5.2.5** The most pertinent and widely used assessment tool for patients, who are bleeding from DUs or are known to have duodenal ulcer disease, is known as the "Rockall Score" (Appendix 6). When applying these criteria retrospectively to Mr Walsh's care his initial Rockall Score (pre-endoscopy) was 4, which indicated a predicted mortality of 24.6%. Following endoscopy the final score when calculated rose to 7 (maximum final Rockall Score is 11) Mr Walsh, therefore, after his first endoscopy had a predicted mortality of 27%. The reviewers feel that the resuscitation techniques and clinical management employed adhered to best National and International Standards. As noted above Mr Walsh's condition stabilised and this was confirmed at repeat endoscopy where he was then noted to have a non-bleeding DU. By further applying Rockall scoring to a gentleman aged over sixty years of age, it is evident there was no indication for elective

surgery. This situation in fact did not change until evidence of re-bleeding appeared late on the evening following Mr Walsh's transfer to Monaghan Hospital.

**5.2.6** It has also been noted by the reviewers, in keeping with evidence-based practice, that Mr Walsh was also commenced on proton pump inhibitor medication following his endoscopy. There is clear evidence in the literature that this type of therapy significantly decreases ulcer re-bleeding and also the incidence of surgery or mortality in patients with bleeding DU. It is also important to note that in elderly patients with bleeding DUs, factors such as ulcer size and abnormal liver function tests, criteria not met by Mr Walsh, are relevant to the incidence of re-bleeding.

**5.2.7** Finally the reviewers are happy that while there is no documented evidence that discussions took place about the possibility of Mr Walsh requiring surgery for recurrent bleeding, the medical staff managing Mr Walsh's DU carried this out and adhered to best practice guidelines. The reviewers also recognise that in other circumstances, in particular if Mr Walsh had not required ongoing rehabilitation from his repaired hip fracture it is very likely that he would have been discharged directly home rather than to another institution.

## **6 Issues relating to Management Structure and Function.**

The foregoing examines the clinical scenario relating to Mr Walsh's death and suggests that many interrelated factors, including management decisions, played a role in creating the circumstances which prevailed on the 13<sup>th</sup> /14<sup>th</sup> October 2005. It is of particular relevance that a body of correspondence exists (which the reviewers have had sight off, Appendix 4) detailing concerns about safety of surgical services in Cavan/Monaghan Hospital. This correspondence runs in time, from Spring 2004 through to Jan '05. The correspondents are Mr Finbar Lennon, Lead Surgeon Drogheda and Independent Medical Advisor to NEHB, Professor Arthur Tanner Director of Surgical Affairs, RCSI and various high ranking NEHB officials. The correspondence refers, in the main, to the alleged failure of health service management to implement the NEHB CEO's directive of 2002 which called for the formation of joint clinical departments between Cavan and Monaghan Hospital and said departments to function as unified entities.

Much of the background to this exchange of correspondence was outside the remit of the reviewers and therefore cannot be commented upon here. However the culmination of the exchange was the directive issued 27<sup>th</sup> October 2004 (Appendix 5b & 5c) restricting surgical practice in Cavan Hospital.

It is the contention in this correspondence that the authorities, having had sufficient time, failed to respond and ensure that an operational situation which could result in the death of Mr Walsh did not occur. It is the belief of the current reviewers that as long as Monaghan Hospital remains open for acute admissions and ambiguity exists regarding levels of surgical service delivery, this operational situation still pertains to some degree.

### **6.1 Consultant Issues**

**6.1.1** In common with many large organisations, the difficulties of Cavan and Monaghan Hospitals may, at least in part, be attributed to dysfunctional interpersonal relationships. Although not necessarily directly relevant to the death of Mr Walsh in October, the reviewers felt that ongoing difficulties in the relationships between individual consultants and the two institutions have made a significant contribution to the environment that resulted in Mr Walsh's death.

**6.1.2** The reviewers felt that there were a number of factors that had allowed this situation to develop including:

- Continuing uncertainty as to the present and future roles of the two hospitals over a sustained period of time
- Ongoing difficulties in relation to consultant appointments and staff, including issues of suspension and re-instatement
- Variable hospital management at local and regional levels resulting in failure to deliver a sustainable future plan
- Varying degrees of unreasonable and/or unrealistic behaviour and attitudes on the part of individual consultants

**6.1.3** The reviewers felt that these factors were frequently inter-dependent where, for example, unreasonable or unsustainable decisions relating to policy or service delivery had allowed individual consultants to develop equally unreasonable and unsustainable positions.

**6.1.4** The reviewers felt that insufficient formal attention has been paid to the working practices of individual consultant surgeons across “the patch” without a process of job planning or regular appraisal. This is, of course, a two way process and requires a commitment from the individual consultants to deliver services, as agreed, in an environment where appropriate facilities, fabric and support are provided. The reviewers felt that, at present, neither of these components exists to a satisfactory level.

**6.1.5** The directive restricting surgical practice (Appendix 5b & 5c) in Cavan/Monaghan Hospital requires further comment. The genesis of this directive was collaboration between the office of Director of Surgical Affairs, RCSI, and the Independent Medical Advisor NEHB. Following a turbulent time in the life of the surgical department in Cavan/Monaghan Hospital a number of audits of surgical practice and outcomes were carried out. Based on this data it was felt appropriate to restrict the practice of locum surgeons at that time. The mechanism of dissemination of this directive was via a letter from the Independent Medical Advisor to the General Manager Cavan/Monaghan Hospital. This was then forwarded by e-mail and subsequently by letter (Appendix 5b & 5c), to the relevant stakeholders, including Mr Mc Murray, as a directive. It has been made clear to the reviewers, from interviews, that this directive included restriction on Mr Mc Murray’s practice. In his considered response to the initial findings of the inquiry Mr Mc Murray responded by saying that ***he did not have any discretion to accept the late Mr Walsh into his care, because Mr Walsh required the very emergency GIT surgery which***

***Mr Mc Murray and his surgical colleagues at Cavan Hospital were expressly prohibited from performing.*** It has also been clarified for the reviewers that the consultant surgical staff in OLOL hospital were informed of the directive and the extra workload it carried but their agreement had not been sought. The staff in OLOL undoubtedly received a number of critically ill surgical transfers, following this, and in general reported to feeling significantly pressurised by this extra workload, while receiving no extra resources.

## **6.2 Institution Issues**

**6.2.1** It was evident to the reviewers during the course of the enquiry that there was a strong sense of both cultural and functional separation between Cavan and Monaghan Hospitals. It is, perhaps, not surprising that such a relationship exists considering the difficulties which have existed between the two hospitals over a period of more than two decades. There is a powerful and substantial body of documentation extending back over this period which illustrates regular periods of dysfunctionality and difficulty in relationships between these two institutions (Appendix 4). For its part, Cavan General Hospital, was originally built at least in part with a view to providing health care facilities for the people of Monaghan town following the projected closure of Monaghan Hospital.

**6.2.2** The Supreme Court ruling on the status of some of the Monaghan Hospital acute facilities, in the early 1980s, established a position that effectively prevented the closure of Monaghan Hospital. This blocked the development of a new model of health care delivery in the region. In fact, the Supreme Court ruling, against the then Minister of Health, directed that Obstetric, Gynaecological and Paediatric services be retained. All these services no longer exist in Monaghan Hospital.

**6.2.3** Since that time the status of Monaghan Hospital has fluctuated widely with considerable uncertainty regarding its role and future in terms of facilities, development of fabric and delivery of service. In addition, for those individuals directly involved with Monaghan Hospital, e.g. nursing, medical staff and local GPs, there is a strong sense that they believe that the general government health care policy is to progressively downgrade the facilities in Monaghan Hospital with an ultimate aim of closing it as a health care facility. This body of opinion also believes that such a policy would be supported in Cavan General Hospital. Consequently, there is a sense that one of their roles is to strongly support Monaghan Hospital and resist any attempts to further down-grade what they clearly perceive as “their”

hospital.

**6.2.4** Against this background, the reviewers felt that it was inevitable that the relationship between the two institutions would at best be distant and poorly integrated and at worst directly antagonistic. The reviewers felt that urgent steps need to be taken to provide clarity and certainty over the future of the institutions both in terms of their functional contribution to service delivery and also in respect to the development of resources, fabric and staffing levels.

### **6.3 Management and Clinician Issues**

**6.3.1** As discussed elsewhere in this report, the reviewers felt very strongly that there was a worrying level of disengagement between clinicians and management. The clinicians appeared to have little respect for managers running the hospitals locally and equally little respect for regional or national management and policy makers who they feel have a substantial responsibility for the current overall position of the various hospitals.

**6.3.2** In turn, there was clear evidence that managers perceived the clinicians, in particular the consultant body, to be difficult and uncooperative. In addition, the well documented difficulties in terms of inter-personal relationships between various consultant surgeons over a number of years in both Cavan and Monaghan are held up as evidence to suggest that the consultant body needs to place its own house in order. The reviewers felt that there was some legitimacy to this view and believe that the consultants have a primary responsibility to the care of their patients. The refusal of clinicians in both Our Lady of Lourdes Hospital and Cavan General Hospital to accept Mr. Walsh in October 2005 (albeit for different and specific reasons) might well be sustainable on the basis of "the letter of the law", **however, the reviewers felt most strongly, that the clinical decisions made on that night were not entirely consistent with good clinical practice.**

**6.3.3** Although the position of the consultant body in both Cavan and Monaghan Hospitals has been volatile over a number of years with individuals being suspended, resigning or being reinstated along with long periods of locum appointments, **the reviewers felt that there has been sustained failure of management to enable resolution of some of these difficulties.**

**6.3.4** Whilst there is a recognition that the issues above, relating to the consultant body are complex and multi-factorial (including some extremely challenging human resources problems) particularly in relation to interpersonal and professional

relationships, ***there remains an irrefutable responsibility on the part of management to ultimately deal with these issues in a manner that protects and maintains standards of patient care.*** Clearly the clinical body must retain a prime role in patient care and be responsible for the maintenance of high standards of clinical practice. At times this role may produce conflict with management strategies that appear to be inconsistent with best clinical practice. It is in this area that the role of good clinical engagement is essential if resolution of disagreements is to be achieved. All successful managers recognize that hospitals cannot be run properly without the support and genuine involvement of the clinicians. ***In turn, realistic and successful clinicians recognize that in any functional institution there must be a hierarchy of decision making and ultimate responsibility and that it is the manager's job to manage. This understanding does not currently exist within the Cavan/Monaghan Hospital axis.***

#### **6.4 Governance Issues**

**6.4.1 *The reviewers felt that the development of a clinical governance programme that is more transparent, well documented and appropriately resourced is an extremely urgent requirement.*** If new consultant surgeon appointments in Cavan are to be allowed to function and prosper to everyone's benefit, it is essential that such properly resourced structures are put in place with immediate effect. This should include the identification of a senior Clinician within the hospitals responsible for the delivery of a Clinical Governance agenda. This individual should have an identified and funded sessional commitment to this initiative and a clearly defined hierarchy of responsibility for patient care. It is of note that the structures developed in the NHS in the UK following the "Bristol Affair" clearly defines the CEO of the individual trusts as having the ultimate responsibility for patient care, in that Trust. The CEO in turn acts through the Medical Director in delivering the governance agenda.

## **7 The Themes from Interviews**

**7.1** Interviewees included nursing staff, local and regional administrative and management staff, medical staff from the relevant hospitals and community based general practitioners. In addition, the review team had the opportunity to meet with several members of the late Mr. Walsh's family. A detailed record was kept of all interviews which were then reviewed using a semi-qualitative thematic analysis using a structured framework approach in an effort to identify *a priori*, emergent and conflicting themes. This section of the report will attempt to detail the identified themes and will, in addition, provide a number of direct quotes (see also section 8) for illustrative purposes. Thematic concordance was such that there is good evidence of sufficient data indicating recruitment to saturation.

**7.2** Individuals being interviewed understood that their comments on the issues raised were personal opinions only and as such they were asked to speak freely and honestly while recognizing that their opinions may be influenced by either their position within the various organizations or their involvement in the care of Mr. Walsh.

**7.3** Interviewees consisted of several groups of individuals;

- Those staff (either nursing or medical) directly involved in the care of Mr. Walsh in Monaghan Hospital.
- Those staff involved in the care of Mr. Walsh in Our Lady of Lourdes Hospital.
- Those staff working in Cavan General Hospital involved in the request to transfer Mr. Walsh.
- Hospital and health board administrative and management staff with either a local, regional or national responsibility (either past or present).

### **7.4 A Priori Themes**

**7.5** There was complete agreement among interviewees that the care offered Mr. Walsh in Monaghan hospital was of the highest quality within the limitations placed on the doctors and nurses as a consequence of the inability to transfer the patient. There was compelling evidence of good team working and a multidisciplinary approach to his care and management with surgical, nursing and anaesthetic staff all directly contributing.

**7.6** A number of staff - both medical and nursing – identified that the episode of

October, 2005 was not unique in several respects. It was reported that there had been several other similar episodes involving patients where transfer from Monaghan Hospital to another centre had not occurred due to the lack of bed availability or refusal on the part of the contacted hospital to accept the patient. These other incidents were different only in that the patient did not die; most related to surgical patients. More than one witness described difficulties re patient transfer out of Monaghan Hospital as a consistent, frequent and regular occurrence – ***“almost a daily problem.”***

**7.7** ***A significant number of interviewees reported that they felt that, in reality, nothing had altered since October 2005 that would significantly reduce the risk of a similar episode occurring again.*** Several individuals felt that in some respects the situation was even worse, in that Monaghan Hospital no longer had surgical staff on site who could even give an opinion in relation to a possible emergency surgical condition. The issue raised was that despite various policy and protocol statements in memoranda issued since October 2005 there was still a very high level of risk in place and the likelihood of a similar tragic episode occurring was very significant. This was one of the most powerful and consistent themes that emerged with almost complete concordance among clinical staff interviewed.

**7.8** ***The reviewers were extremely concerned by the level of stress apparent in the medical and nursing staff who were directly involved in the care of Mr. Walsh during his hospital care in Monaghan Hospital.*** It was evident that the staff felt extremely demoralized and depressed by this tragic episode. In addition, a number of individuals articulated high levels of resentment that public dialogue concerning this event had appeared to implicate them in a failure to provide appropriate management for Mr Walsh. Most staff interviewed described feelings of being “let down” and blamed for this episode by an administrative structure that they felt was responsible for the development of the circumstances in the first place. The reviewers were concerned that little effort appeared to have been made to provide support to the staff involved in such a traumatic episode.

**7.9** The reviewers were impressed by how little blame was placed by any member of the nursing or medical staff in Monaghan Hospital on the staff of Cavan General Hospital for the failure to accept the patient. The reviewers were repeatedly told that Cavan General Hospital itself was being stretched to breaking point due to lack of facilities and was regularly simply not in a position to accept patients when

asked. A number of individuals reported personal experience of difficulties in transferring patients and concluded that there were regular issues of lack of access to critical care facilities in either Cavan General Hospital or Our Lady of Lourdes Hospital. ***The consistent theme that emerged from this was a clear belief and recognition that neither Cavan Hospital nor OLOL Hospital had sufficient capacity to deal with current patient demand efficiently.*** This capacity shortfall would be further exacerbated by any further demand resulting from a closure of or reduction in Monaghan Hospital services. Many interviewees made clear statements indicating that both these larger centres were in urgent need of significant investment to increase capacity.

**7.10** ***The reviewers noted a very clear lack of engagement between management and clinicians at virtually all levels.*** From the interviews there was clear evidence of a lack of productive dialogue between the groups and the confidence of medical and nursing staff in the ability of management to alter or improve the structures was virtually zero. The reviewers were repeatedly told that there was a major deficiency in the political leadership required to make clear decisions.

**7.11** Many individuals reviewed the history of the relationship between Cavan and Monaghan Hospitals and reminded reviewers that there had been many areas of antagonism and lack of co-operation. While the reviewers did not feel that such institutional antagonism was unique to these two hospitals, it was clear that there was no meaningful engagement on an institutional level in a way that might be expected. For example, although both Cavan and Monaghan Hospitals are functionally and managerially considered part of the same entity, it was quite evident that staff working in each institution felt very little ownership for this concept. From an organizational standpoint, the process of amalgamating these two institutions had visibly failed with minimal engagement on either a management or clinical level. In addition, despite the fact that Our Lady of Lourdes Hospital has clear functional and clinical service links with both Cavan and Monaghan Hospitals, many staff there displayed very little knowledge about the facilities and services available at Monaghan Hospital and certainly no sense of allegiance, obligation or support for the other hospitals.

**7.12** ***In addition to this lack of knowledge about Monaghan Hospital, there was a general view portrayed by non-Monaghan staff that the clinical management of patients in Monaghan Hospital was very poor.*** Worryingly, several members

of nursing and medical staff from Monaghan Hospital interviewed by the reviewers presented a similar assessment of the care of patients within Monaghan Hospital.

- 7.13** In terms of the specific events of October 2005, the reviewers felt that the perception of staff in Our Lady of Lourdes Hospital and Cavan General Hospital about the standard of care provided to Monaghan Hospital patients, may well have coloured attitudes when it came to considering the request for the transfer of Mr. Walsh. ***In addition, the Monaghan doctors reported feeling subservient to both Cavan and OLOL surgical staff who were accused of treating their Monaghan colleagues in a patronizing and disrespectful manner.***
- 7.14** ***The reviewers were repeatedly told that the death of Mr. Walsh was not primarily the fault of clinical staff in any hospital. Rather, it was the consequence of an organizational structure put in place that did not take into account the clinical realities and the restrictions on service delivery.*** Several individuals commented that neither Our Lady of Lourdes Hospital nor Cavan General Hospital could be reasonably expected to take patients from Monaghan Hospital without significant extension of the facilities at these sites. It was also made clear to the reviewers, by a range of individuals, that the protocols for patient transfer remained ambiguous and did not place clear obligation on the part of either Cavan General Hospital or Our Lady of Lourdes Hospital to accept a patient from Monaghan Hospital.
- 7.15** In addition to the psychological trauma clearly suffered by a significant number of staff directly involved in the care of Mr. Walsh in Monaghan Hospital, a range of individuals interviewed expressed anger and resentment about being questioned by an inquiry established by a Health Service “which had set this all up anyway”.

## **8 What people said**

**8.1** As is standard practice in such a qualitative analysis the following section includes a number of verbatim quotes from various witnesses interviewed during the course of this enquiry:

### **8.2 *In relation to current (new since 14<sup>th</sup> October 2005) surgical situation in Cavan/Monaghan hospital complex:***

**8.3** *“What happened to the unfortunate Mr Walsh could happen again today because nothing had been put in place that would stop that happening”*

**8.4** *“Cavan/Monaghan is still a time bomb ticking”*

**8.5** *“The whole place is a recipe for disaster”*

**8.6** *“I think if Monaghan were going to be taken off call, theatres closed, proper facilities should have been put in place in the other hospitals that there would not be a problem on a night like this”.*

**8.7** *“Well I would prefer to see no facility there. We have a treatment room at the moment where the same thing is going to happen. It happened very shortly after that, a similar episode where we had huge difficulty in getting somebody transferred. It is going to happen again.”*

**8.8** *“But it is happening all the time....., I do not know whether I am suppose to say this or not, but this is the way it is.”*

### **8.9 *Referring to future links between Cavan and Monaghan Hospitals:***

**8.10** *“Of course, that process which involves human beings is of course subject to all the variability of human beings including human error etc, and quite relevantly in this set-up to all the influences brought about by personal relationships and interpersonal relationships and the strengths and weaknesses that they have. And also the strengths and weaknesses between the institutional relationships which, you know appear to have a very significant influence on this as well.”*

**8.11** *“Well I really don’t know how they operate in Cavan or how they liaise with each other.”*

### **8.12 *Referring to historical policy in old NEHB region:***

**8.13** *“And because of policy, five hospitals have been kept open, and unfortunately Drogheda was expected to act as a regional hospital without the resources.”*

*“this needs political leadership and you are never going to get that properly in a country like Ireland”*

**8.14 In relation to transfer of sick patients between hospitals.**

**8.15** *"I just take the patient. Now, I would like to know if the patient was fit to travel. Because once I say I'll take a patient, I feel I'm responsible."*

**8.16** *"My general feeling would be that we would accept the patient and then I would find a bed. But at the same time, I've always checked the bed situation."*

**8.17** *"Well, my logic is that they're better off waiting for a bed in a recovery unit post the procedure to save their life than waiting in an A&E facility getting sicker and sicker and sicker."*

**8.18** *"Well I think it is a downright disgrace. Number 1 I think it is a disgrace from the patient's point of view ....., from the stress that the staff are put under. "Every single member of staff is under huge stress. They're aware that nothing is being done".*

**8.19** *"I would say it is disastrous to tell you the truth....., I am from .....(overseas) and I know we have much poorer conditions with the health system and all but we don't have a thing called, we don't accept"*

**8.20** *"Well there should be no question about whether the patient is accepted or not."*

**8.21** *"Absolutely not. They shouldn't be allowed say no."*

**8.22 In relation to where the blame lies.**

**8.23** *"And I'm dismayed at that. Because my view is that while I accept there may well be professional failings that occurred in relation to this specific case, my view is that the greater responsibility is with the institutions."*

**8.24** *"I don't blame Cavan or Drogheda. It goes higher than that. The facilities just aren't there to cope."*

**8.25** *"At the end of the day, it's us the Health Board is going to try to hang. They are not going to take responsibility for it."*

**8.26 Comments on the future.**

**8.27** *"The fact is that it was clear to me many, many years ago, that the only way one could survive in a region like this with five hospitals is you had to have some degree of collaboration and amalgamation."*

**8.28** *"If anybody comes up with any more cock-and-bull compromises to satisfy every Tom, Dick and Harry, we can wave our hat at it."*

**8.29 Other general comments and issues of morale:**

**8.30** *"And the point is that what happened to that person was a calamity of huge proportions and I don't think even some of our colleagues appreciate that. It is an*

*absolute calamity, as indeed the Francis Sheridan case was a calamity of massive proportions and it wasn't appreciated by the profession sufficiently. And it wasn't appreciated by the institutions, including the Medical Council and the Department of Health."*

- 8.31** *"I don't know if you can begin to believe the stress, the worry, the tension there is with something like this, and people coming in and nearly begging for a bed in another hospital and wondering will they get there."*
- 8.32** *"Will there be a bed, will there not be a bed, will they be accepted? This is the reality of it. This can go on for hours in the Treatment Room."*
- 8.33** *"Well, to tell you the truth, the morale is at an all time low."*
- 8.34** *"Every time you lift the paper there's something else about Monaghan."*
- 8.35** *"Like this is a situation that we'd be faced with weekly and that it is very frustrating when the other hospitals aren't really listening or offering us a life jacket."*
- 8.36** *"Well, I feel very angry that we are put in this position and still remain in that position.....we're wide open and we're the ones in the front line dealing with the family's anger and dealing with the doctors frustrations. I feel very very angry that we still remain in that situation."*
- 8.37** *"......It is two nights later we have the same situation trying to transfer and arguing over it. It is a weekly if not daily occurrence at this stage....arguing and ringing around three or four hospitals. It should be there that they have to accept and that's it."*
- 8.38** *"We were vulnerable then. But we are ten times more vulnerable now."*

## 9 Developments in Monaghan/Cavan Hospitals (since 13<sup>th</sup> October 2005)

### 9.1 Current Arrangements

9.1.1 Since the events of October 13/14 2005 a number of changes has taken place in terms of service delivery at Monaghan and Cavan Hospitals. Essentially three issues are worthy of consideration:

- Changes to the current service provision at Monaghan Hospital
- Current arrangements in relation to transfer of patients from Monaghan Hospital
- The development of the Lead Surgeon role in Cavan Hospital.

These issues are among the most prominent themes raised by the interviewees during this inquiry. A consensus emerged which suggested that despite significant changes in service delivery since Mr. Walsh's death, there was still a high level of risk that these events could be repeated. Thus the reviewers felt that a remit existed within the Terms of Reference to discuss the above.

9.1.2 Since October 2005, all in-patient surgical activity has ceased at Monaghan Hospital. The existing NCHDs have been largely re-deployed to Cavan Hospital and only one of the Monaghan Consultant Surgeons remains, having assumed a new role within the Treatment Room at Monaghan Hospital. The Treatment Room, which is open 24 hours a day, is functioning under a new operational policy whereby most patient care is both nurse led and delivered (Appendix 4).

9.1.3 Patients presenting to the Treatment Room are assessed either by nurses or by the remaining Consultant Surgeon and those with conditions requiring possible surgical intervention are referred to Cavan Hospital. It is not clear at present whether each referral to Cavan Hospital either requires or actually involves an individual contact with Cavan prior to patient transfer. The reviewers were told that patient transfer may be by ambulance, where appropriate, or by the patient's own means of transport. There is currently an evolving system whereby patients, with less urgent surgical conditions, may be seen in an outpatient clinic setting by one of the visiting Cavan surgeons who are on site to undertake "day-case surgery" using the new operating theatre facilities. ***However this process can only take place in normal "office hours" and there is no surgical presence at all on site out-of-hours***

**(Appendix 4).**

- 9.1.4** Those patients presenting with “medical” conditions are assessed by the resident medical staff within Monaghan Hospital and, where appropriate, may be admitted to in-patient beds. The reviewers were informed that a range of medical conditions is treated in Monaghan Hospital up to and including patients with acute myocardial infarction and that there are some critical care facilities to support this service.
- 9.1.5** At night time and at weekends there are no surgical staff on site and no facility to provide a surgical opinion relating to in-patients (or Treatment Room attendees) outside of telephone contact to Cavan Hospital or actual transfer of the patient to Cavan or another hospital.
- 9.1.6** At present, surgical services are limited to day-care type operations performed either under local or general anaesthetic by one of the consultant surgeons who visit on a daily basis. This developing service proposes to allow for half-day operating to be combined with endoscopy procedures and a series of patient consultations (either patients referred from the treatment room or medical in-patients requiring a surgical opinion).
- 9.1.7** Endoscopy services in Monaghan Hospital have been enhanced by the purchase of new imaging and endoscopic equipment. ***However the service is not available out-of-hours and medical in-patients requiring emergency endoscopy have to be transferred to another institution.***

**9.2 Current Protocols for Patient Transfer**

- 9.2.1** This matter is perhaps the central issue of the entire clinical incident and therefore a vital component of this report. As noted elsewhere in the report, staff in Monaghan Hospital were united in the single view that the risk of a repeat of the events of October 13/14 2005 had not been meaningfully reduced since that time.
- 9.2.2** Following the death of Mr. Walsh, attempts were made to alter arrangements and protocols for patient transfer from Monaghan Hospital. In a memorandum dated 21<sup>st</sup> October 2005 (Appendix 4), from Mr. Chris Lyons, Hospitals Network Manager, HSE North East, it was stated that “all requests for transfer to the Cavan Hospital site and to OLOL Hospital, Drogheda from Monaghan Hospital should be granted and processed immediately”. Subsequently, a further memorandum from Mr. Lyons dated 3<sup>rd</sup> November 2005 (Appendix 4), which was intended to clarify the preceding memo following concerns raised re the possibility of large numbers of inappropriate

transfers, was issued. These concerns were raised by a number of consultants in the region, the most prominent of whom was Mr Finbar Lennon (Lead Surgeon Drogheda). Mr Lennon stated in a letter to the Irish Times, published after the 21<sup>st</sup> Oct. memo, that strict application of Mr Lyons's directive would "put patients at risk and would compromise the exercise of professional discretion". In Mr Lyons's second (3<sup>rd</sup> Nov 2005) memo it is suggested that the transfer process should be based on dialogue between appropriate clinicians to ensure the clinical appropriateness of any transfer. This is, of course, standard clinical practice and Mr Lyons stated that he had no wish to encroach on clinical matters. However, the reviewers feel that an unintended consequence of this 2<sup>nd</sup> memo was to reintroduce a degree of ambiguity into the process and specifically, to remove a clear and absolute obligation on the part of Cavan or OLOL Hospital to accept the request for patient transfer. ***In other words, arrangements following this memo still included the possibility of both Cavan and OLOL hospitals refusing to accept a Monaghan patient if the receiving clinician saw fit. The failure to achieve transfer of Mr Walsh was due to breakdown in clinician to clinician communication and the inability to establish "appropriate transfer status".***

**9.2.3** ***In summary the reviewers believe that by removing the implied obligation on the part of Cavan or OLOL Hospitals to accept a patient in such circumstances, the 2<sup>nd</sup> memorandum of 3<sup>rd</sup> November represented a failure of governance/management and continued an unacceptable level of patient risk.*** The reviewers believe that the death of Mr. Walsh produced an absolute governance responsibility to ensure that a similar episode never occurred again. The memorandum of 21<sup>st</sup> October was a real attempt to establish with certainty and clarity a protocol that would absolutely and definitively ensure that no Monaghan Hospital patient would die as a direct consequence of transfer being refused by another hospital. *(At time of writing the reviewers have been given to understand, following further directives to and discussions with the Cavan Hospital Surgeons, that this transfer imperative has now been made absolute).*

This is to be commended.

### **9.3 The Role of the Lead Surgeon**

**9.3.1** In light of a number of comments made by interviewees the reviewers wished to consider the present and future role of the Lead Surgeon. An appointment sanctioned by Council of the Royal College Surgeons Ireland (RCSI). In particular, the reviewers wished to consider the Lead Surgeon's role in the context of several background factors. These included:

- The previous involvement of the Director of Surgical Affairs and other interventions from the RCSI
- The continuing presence of some dysfunctional elements in consultant working practice
- The impact of surgical practice on training standards and opportunities

**9.3.2** Although RCSI may see its role (like the Colleges in London and Edinburgh) as responsible for training and accreditation, as this relates to surgical standards, the reviewers felt that the concept of RCSI providing special input into the problems of Cavan and Monaghan was appropriate. This is particularly pertinent in a small country like Ireland where individual surgeons, delivering surgical services, draw their credibility and accreditation from RCSI. The reviewers also note that this was entirely in keeping with the history of individual reviews and reports undertaken by RCSI, along with the personal commitment of the Director of Surgical Affairs at RCSI (Professor W.A. Tanner).

**9.3.3** The reviewers felt, however, that the current arrangement, that is, external Lead Surgeon, albeit endorsed and supported by RCSI, was not ideal. There was a degree of uncertainty as to the job description and remit for the Lead Surgeon which extended to uncertainty over weekly timetables, the frequency and duration of presence in either Cavan or Monaghan Hospital and the tenure of this appointment.

**9.3.4** The reviewers felt that the incumbent Lead Surgeon, Mr J Murphy, had made many genuine attempts to contribute to the resolution of the difficulties. There seems good reason to suggest that Mr. Murphy had introduced developments that were beneficial in terms of clinical practice and education. However, it was clear to the reviewers that although significant progress had been made in some areas that might be loosely termed clinical governance, the process had not been without problems and, therefore, had not been entirely successful. In particular the process,

as it currently stands, does not have any formal clinical governance structures which the reviewers feel is imperative. The background dysfunctionality that existed in Cavan General Hospital at the material time led to the involvement of RCSI and the establishment of the Lead Surgeon post. Commonsense would suggest that a formalised process of clinical governance would provide the safest mechanism of preventing such dysfunctionality in the future. The known difficulties in Cavan Hospital indirectly contributed to a failed mechanism of transfer for Mr Walsh.

- 9.3.5** The level of engagement of the Cavan/Monaghan consultants in the process was worryingly low. While it was recognised by the reviewers that this lack of engagement could not fairly be blamed on the Lead Surgeon, it was nonetheless undeniable that it remained a significant issue. In addition, it was clear that there was not universal ownership of the process by the relevant stakeholders.
- 9.3.6** There was clearly a significant body of opinion that felt that the Lead Surgeon did not spend enough time “on the ground” in Cavan/Monaghan and that this fact alone was a significant contributing factor to the lack of engagement. The reviewers felt that there was some legitimacy to this contention while recognising that the Lead Surgeon had only been appointed on a part-time basis and, therefore, could not realistically be expected to be in Cavan or Monaghan Hospitals for a substantial part of the working week. At time of writing the reviewers have been given to understand that the Lead Surgeon has successfully completed his identified role and left with the thanks and appreciation of both RCSI and administrative authorities in the North East Area.
- 9.3.7** Overall, the reviewers felt that RCSI should formalise its commitment to this ongoing process in a more transparent, clearly defined and accountable manner. The reviewers felt that the issues should once again be placed within the remit of the Director of Surgical Affairs, RCSI. However, the reviewers also felt that for this to be a successful development the terms of reference for this commitment would need to be established with clear end points, time frames and outputs. In addition, these terms of reference would need to gain agreement and ownership from the individual stakeholders including hospital managers and clinicians.
- 9.3.8** The reviewers felt that the Director of Surgical Affairs should resume responsibility from the Lead Surgeon as soon as practically possible. The role of RCSI should now be clearly defined and Terms of Reference made explicit. At time of writing the reviewers are given to understand that RCSI is developing governance guidelines

which will oversee and guide its involvement in any such clinical and service problems in the future.

#### **9.4 Current Clinical Services in Monaghan Hospital**

**9.4.1** *The reviewers felt that the current clinical services provided by Monaghan Hospital are unacceptable and unsustainable. In addition, it was felt that the level of clinical risk has in fact significantly increased (rather than decreased) as a consequence of the actions taken since the death of Mr Walsh in October 2005.*

**9.4.2** The present clinical service provided by Monaghan Hospital faces a number of challenges. Two of these are worth considering in further detail.

**9.4.3** At present the hospital offers essentially a full medical admission service with a significant number of in-patients under the care of various consultant physicians. This includes patients who have been admitted acutely with life threatening conditions, including myocardial infarction.

**9.4.4** Monaghan Hospital provides a degree of coronary critical care and treats patients as required including the use of thrombolysis post infarction.

**9.4.5** In contrast, since the events of October 2005 there are no surgical in-patients and no surgical staff on site out-of-hours. Monaghan Hospital surgical services have been reconfigured and now provide ambulatory care delivered by visiting surgeons on a daily basis with no in-patient consultation service.

**9.4.6** *The reviewers felt very strongly that this model of service delivery is unsafe and unsustainable.* It is unsafe to maintain a significant body of medical in-patients undergoing a range of interventions, up to and including thrombolysis, without appropriate backup. There is at present no capacity or facility for a surgical opinion to be given on any medical in-patient within the hospital outside of a direct transfer to another hospital.

**9.4.7** Whilst it might appear intuitively obvious that such patients should be transferred to Cavan Hospital if required, there is at present no specific, documented or unambiguous directive that places an obligation on Cavan Hospital to accept such patients. (However, at the time of report completion, the reviewers have been given to understand that such an unambiguous directive is being put in place).

**9.4.8** The reviewers felt that even if such an obligation to transfer a patient were established, it is not acceptable, in current clinical practice, to have isolated medical

in-patients who have no access to appropriate backup services and facilities. The obvious immediate pressure placed on the system, should Monaghan in-patients be relocated, would be at Cavan and Drogheda Hospitals although given that HSE North East also includes Navan and Dundalk Hospitals, consideration could be given to absorbing the pressures across the region. However, the most satisfactory resolution for absorption of Monaghan in-patient workload would be an equivalent expansion in services in Cavan and Drogheda Hospitals, with proper resources to achieve this. It is even possible that this could be achieved rapidly by the innovative use of some of the new modular in-patient facilities. Cessation of in-patient services at Monaghan Hospital would definitively remove the risk of a similar clinical incident occurring again.

**9.4.9 *While it is recognised that suitable alternative arrangements must be in place, it is the recommendation of the reviewers that in-patient medical services in Monaghan Hospital cease at the earliest possible opportunity.***

## **10 The Future of Clinical Services in Monaghan Hospital**

- 10.1** The reviewers received many comments during interviews relating to potential future models of service in Cavan/Monaghan and a significant number in relation to the whole North East region. Thus the reviewers felt that pertinent comments in this area were warranted in the hope that suggestions taken on board would eliminate the risk of similar clinical incidents occurring again.
- 10.2** There is extensive documentation (extending back over more than two decades) that has addressed the issue of the number of hospitals providing clinical services in the North Eastern region. While these documents demonstrate very little overall agreement as to the ideal model of service delivery for the region, there is virtually no disagreement that five significantly sized hospitals (Our Lady of Lourdes Hospital, Drogheda; Our Lady's Hospital, Navan; Cavan General Hospital; Monaghan Hospital; The Louth Hospital, Dundalk) are too many.
- 10.3** Whether true or not, those interviewed report that staff and community in Monaghan believe policy makers wish to see the closure of Monaghan Hospital as soon as possible. This sustained belief is a major contributing factor to the very poor morale of the staff in Monaghan Hospital and continuing difficulty that has plagued attempts to resolve the issues.
- 10.4** Having interviewed a wide range of staff from various constituencies as well as visiting Monaghan Hospital, the reviewers felt that some solutions were reasonably clear when taking into account the practicalities of the environment.
- 10.5** Monaghan is a relatively small, but significantly sized, town where the hospital represents a significant social and employment entity. ***The reviewers felt that if one takes into account the social and economic issues as well as the simple service issues of healthcare delivery, it might be considered unreasonable to close Monaghan Hospital entirely.***
- 10.6** ***The reviewers felt equally strongly, however, that the re-development of Monaghan Hospital as a comprehensive care facility with a wide range of both medical and surgical inpatient services is unsustainable in the present environment.*** There are many reasons why this is true including issues of service duplication, critical mass, recruitment and retention of highly skilled staff in specialties that are hard pressed nationally (such as radiology, surgery, anaesthetics). ***The reviewers further felt that it is essential that the obvious***

***validity of this position be established and accepted as soon as possible.***

- 10.7** The reviewers were extremely impressed with the motivation, enthusiasm and commitment of the various staff they met in Monaghan Hospital. There was a clear sense of pride in the institution as well as genuine and enthusiastic desire to provide the best care possible for the local population. This was, however, tempered by the realisation that the fabric of the institution had deteriorated significantly over the years and was in need of significant and urgent upgrade.
- 10.8** The reviewers felt that in order to deliver the significant and real changes necessary to bring about an improvement in risk levels, a resolution of the service delivery disputes, a clarification of consultant working practices as well as a recognition and clarification of the role of Monaghan Hospital in healthcare delivery, significant steps would need to be taken. The reviewers felt most strongly that significant (but relatively modest) levels of resource could be invested immediately into Monaghan to provide an alternative institution for healthcare delivery.
- 10.9** ***One model for Monaghan Hospital could be its re-development as a comprehensive, diagnostic and ambulatory care facility.***

Because of the significant pre-existing buildings estate in Monaghan, careful thought should be given to the practicalities of site re-development. The reviewers felt, however, that it is essential that the end result is a facility of the highest standards of fabric and equipment.

- 10.9.1** A comprehensive outpatient service could be provided within this facility. Included in this would be physiotherapy, social work and occupational therapy. In the field of diagnostic facilities, it is recommended that a properly equipped endoscopy unit be established providing both upper and lower diagnostic and therapeutic interventional endoscopy.
- 10.9.2** Consideration should be given to providing both multi-slice, fast sequence CT scanning as well as MRI scanning services on site. These cross segmental imaging facilities could be established in addition to routine radiology including barium screening services.
- 10.9.3** Consideration should be given to establishing a facility for breast screening imaging services.
- 10.9.4** In the arena of surgical services, consideration should be given to the provision of a

full range of ambulatory care with operations being performed as day cases in this facility. While both general and local anaesthetic procedures could be carried out, it would not be recommended that any facility be provided for overnight stay of patients. Any patient who required re-admission to hospital or direct admission following surgery should be transferred immediately to Cavan Hospital. It is, therefore, essential that the protocols and guidelines that manage and develop surgical practice in this new facility be established and developed with particular care and attention.

- 10.9.5** It is recommended that the current operational policy of the treatment room be suspended immediately. The reviewers felt that the treatment room should function only as a nurse-led minor injuries unit. It was felt that there was little realistic justification for maintaining any system within Monaghan that allows ambulance-delivered emergency care. The new institution envisaged must function as a stand alone entity that is functionally largely independent of the hospitals within the region. ***In order to emphasize the functional independence of this newly proposed institution it is strongly recommended that it ceases to use the word hospital in its title.***
- 10.9.6** The reviewers felt that it would be reasonable to consider additional services that might be provided in the newly established healthcare facility. These are: 1) elderly care; 2) rehabilitation/convalescence care; 3) hospice care/palliative care. The reviewers would wish to emphasize, most strongly, that these in-patient bed facilities should be separate from the main healthcare facility. They should be established purely as non-acute care with some potentially being delivered by primary care practitioners. Other services may require visiting specialists. In the absence of appropriate levels of commitment and input from the primary care community, the reviewers feel that these additional facilities should not be developed, although they may be very necessary.

**10.10** In summary, the reviewers felt that this proposal would achieve a number of objectives at the cost of a relatively modest, extremely cost effective and much needed investment of capital and revenue resource. The new healthcare facility could:

- Provide something that Monaghan, both the County and Town could be proud of, that is not present elsewhere and that establishes clearly its role in delivery of health provision
- Resolves once and for all the arguments and disputes over the role for Monaghan Hospital in terms of patient care
- Establishes clearly the relationship between Monaghan and the neighbouring hospitals
- Abolishes entirely the possibility of a repeat of the events of October 2005.
- Provides core services that would offer healthcare facilities (diagnostic and therapeutic), for a large range of patients throughout the region.

## **11 Conclusion**

- 11.1** Patrick Walsh's death, while it may have been inevitable, was avoidable in the circumstances in which it occurred. It is highly likely that he would have died within a short period of the onset of his second catastrophic haemorrhage from his duodenal ulcer. However, he did not get the therapeutic opportunities afforded to most patients in such circumstances because of issues of process and policy rather than clinical indications.
- 11.2** The hospital in which he found himself was precluded from performing such lifesaving surgery as he would have required. The sister institution claimed it was not allowed to perform such complex surgery and backed this up with documentary evidence supporting this stance. However, it did have the necessary critical care bed. The hospital from which he had been transferred only hours previously, had the clinical latitude and discretion to refuse patients despite being nominally the Regional Centre, but also had the required bed available. The central city hospital contacted had beds but all were committed to patients in transit internally and from elsewhere and was more than likely too distant to be a realistic option in the circumstances.
- 11.3** The staff of all three local hospitals involved had experience of challenging communications on many previous occasions and much of this history coloured the decisions which ultimately blocked Mr Walsh's transfer to an institution which could have provided his surgery. The genesis of these challenging communications lies in a long history of disengagement between health service management and the consultant body and a failure of real amalgamation between two of the hospitals. Many opportunities have presented themselves in the past to both management and clinicians to put in place systems which would have prevented the circumstances of this case. There was an almost singular lack of development of any clinical governance structures in the NEHB as it was, HSE NE as it is, to which clinicians and managers could sign up. Similarly, the existence of the post of Risk Manager where the incumbents are termed Risk Advisors, indicates this critical lack of engagement.
- 11.4** It is interesting to speculate, what influence the age of the patient (in his mid 70s) had on the transfer issue. This transfer may not have been such an issue had Mr Walsh been much younger. The age issue was not one that reached a level of

saturation in the qualitative analysis undertaken and age did not emerge as an interview theme, unlike some of the more prominent and contentious issues discussed in the body of this report. Thus the existence or otherwise of systemic ageism did not arise for comment by the reviewers.

- 11.5** The recommendations within this report are mostly suggestions re clinical governance structures and ultimate institutional responsibility for patient safety and best clinical practice. Much emphasis has been placed on the patient transfer issue which as yet is not satisfactorily resolved. However a solution to this is in evolution to reduce a residual high level of risk. Comment has been made on the institutional arrangements in the North Eastern Region because much of the data gathered relating to Mr Walsh highlighted problem areas. However, the reviewers have, where possible, concentrated on making suggestions and describing options, related to how things are or might be done in other health services rather than specifying a model of service which should be put in place.
- 11.6** It is recognised from the many interviews and discussions that were held, that there is both a local and national political will to change things radically in the North East. The reviewers felt thus that quite significant changes are likely in the near future which will markedly enhance patient care in the region. The hope would be that whatever institutional structures are chosen for the longer term future of acute healthcare in this region, they will be based on a robust platform of solid mechanisms of clinical governance.
- 11.7** It may be that the specific recommendations in relation to service provision at Cavan and Monaghan hospitals contained within this report will be overtaken by these wider ranging and radical regional changes. Even allowing for this possibility, the recommendations made within this report represent the minimum necessary to reduce patient risk and it remains the case that retaining the current status quo cannot be an acceptable option.

## **Appendix 1**

### **Terms of Reference in respect of inquiry into death of Mr. Patrick Walsh**

The following are the Terms of Reference in respect of this enquiry:

- To examine the circumstances pertaining to the death of Mr. Patrick Walsh RIP at Monaghan Hospital on the 14<sup>th</sup> October, 2005.
- The scope of this review shall cover the period commencing with the admission of Mr. Walsh to Our Lady of Lourdes Hospital, Drogheda on 21<sup>st</sup> September, 2005 and subsequent death in Monaghan Hospital.
- The review team will focus on the clinical management of Mr. Walsh and also examine to what extent non clinical factors may have influenced the care received by Mr. Walsh.
- The review team will examine protocols and procedures relevant to this incident and to inquire into their application in this case, taking into account prevailing standards of best practice and also examine all documents generated by any review of the incident by the management of the HSE North East.
- The review team will be chaired by Mr. Declan Carey, Consultant Gastrointestinal Surgeon at Belfast City Hospital, Belfast in association with Professor John Monson of the Academic Surgical Unit at the University of Hull.
- The review team will access any additional external specialist expertise which they deem necessary.
- The review team will provide a report to the Director of the National Hospital's Office in relation to this case and will make such recommendations as it sees fit.

## Appendix 2

### **Guidelines for the conduct of the Independent Review into the circumstances surrounding the death of Mr. Patrick Walsh, Deceased on the 14<sup>th</sup> October 2005**

1. An independent review into the circumstances surrounding the death of Mr. Patrick Walsh, deceased on the 14<sup>th</sup> October 2005 has been commissioned by the Director of the National Hospitals Office. The Independent Review Team members are Mr. Declan Carey, Consultant Surgeon and Honorary Senior Lecturer, Belfast City Hospital and Professor. John R.T. Monson, Professor of Surgery, University of Hull. The review is non adversarial, its workings are informal and it will be undertaken in private. The review team will seek to observe fair procedures.
2. The Review Team will invite and conduct interviews with medical and nursing staff and management personnel of the hospitals, Health Service Executive and any other relevant persons associated with the provision and/or administration of care and treatment of the deceased as it considers necessary and will also invite nominated members of the family of the deceased to attend for interview.
3. Witnesses may be invited to submit a written statement in advance of an interview by the independent review team. Statements will not be sworn, and will be obtained on a voluntary basis. Whilst there is no obligation to make statements or provide information and there is no obligation to answer any question, it should be noted that the independent review team has a duty to report this to the Director of the National Hospitals Office in accordance with the terms of reference. Non-cooperation of invited witnesses will be noted in the report.
4. The Terms of Reference and Guidelines will be made available to every witness.
5. Witnesses may be called for interview by the team and interviews will usually take place at a mutually agreed venue. Advance notice will be given of any change of venue. It should be noted that interviews will be recorded and transcribed.
6. Witnesses may be accompanied to interview e.g. by a colleague, friend or lawyer, such persons will not have the right to examine the witness or make submissions to the interviewers or participate in the interview. However, the interview may be temporarily suspended to allow the witness to consult with such companion. Please note however that the Independent Review Team do not have any power to award legal fees or costs.
7. If, during the course of an interview, a witness provides relevant information critical of a third party which the Review Team deems relevant to the inquiry, that information will be furnished to such a third party for a response. The identity of the person making such relevant criticism will not be disclosed to the third party unless absolutely necessary in the interests of fair procedures. In so far as it is necessary and appropriate, the third party's response, or the relevant position, will be furnished to the witness for further response/comments.

8. All information and statements provided to the independent review team is protected by qualified privilege, which means that a witness may speak freely to the team. Qualified privilege applies provided the information given is truthful and not motivated by malice. Any publication in the final report will be a publication by the Independent Review team in accordance with the terms of reference and is protected by qualified privilege.
9. Witnesses may be re-interviewed by the Independent Review Team as the occasion demands. Any person being re-interviewed will be given sight of a record of his or her previous interview or relevant portions thereof, if requested.
10. Interviewees are required to maintain confidentiality in respect of any information given to them for the purposes of the review.
11. If significant matters are raised which might affect the reputation and good names of individuals or bodies, the Independent Review Team reserves the right to deal with these consistent with the rights of the parties involved and commensurate with its Terms of Reference.
12. The Independent Review Team will be granted unrestricted access to all medical records of the deceased held in Our Lady of Lourdes Hospital, Drogheda, Monaghan Hospital as well as ambulance records and if applicable other hospitals. This includes all other documentation or files held relevant to the deceased's care, to include any documents concerning relevant policies or changes thereto created by the management staff of the HSE area.
13. In addition, the Review Team will be furnished with all relevant documents to include protocols and practices then in existence, or changes thereto, governing the management, treatment and transfer of patients between all the hospitals located inside the HSE area as well as with hospitals outside the HSE area.

### **Appendix 3a**

#### **People interviewed:**

Dr. Imtiaz Hussain, Surgical SHO, Monaghan General Hospital  
Dr. Iona Duffy, General Practitioner, Co Monaghan  
Mr. Kiran Jha, Surgical SHO Acting Registrar, Monaghan General Hospital  
Dr. Mujeeb Khan, Consultant Anaesthetist, Monaghan General Hospital  
Dr. Seamus Clarke, General Practitioner, Clones, Co Monaghan  
Dr. Suhail Baloch, Anaesthetic Registrar, Monaghan Hospital  
Mr. Ashghar Ali Shaikh, Surgical Registrar, Monaghan General Hospital  
Mr. Chris Lyons, Network Manager, HSE North Eastern Area  
Mr. Declan Reidy, Consultant Orthopaedic Surgeon, Our Lady of Lourdes Hospital  
Mr. El-Masry, Consultant Surgeon, Our Lady of Lourdes Hospital  
Mr. Emile Aboghaly, Surgical Registrar, Cavan General Hospital  
Mr. Finbar Lennon, Consultant Surgeon, Our Lady of Lourdes Hospital and Former Independent Medical Advisor to NEHB  
Mr. Gerry Clerkin, Risk Advisor, Cavan/Monaghan Hospitals  
Mr. James Murphy, Lead Surgeon, Cavan General Hospital  
Mr. John O'Brien, National Hospital Office, HSE  
Mr. Joseph McGrath, Consultant Surgeon, Our Lady's Hospital  
Mr. Kevin Molloy, General Manager, Cavan General Hospital  
Mr. McAleese, Consultant Surgeon, Monaghan General Hospital  
Mr. McMurray, Consultant Surgeon – Cavan General Hospital  
Mr. Omer Abdul Rahim, Surgical Registrar, Our Lady of Lourdes Hospital  
Mr. Pat McLoughlin, National Hospital Office, HSE  
Mr. Paul McCormack, Specialist Registrar in Surgery, Our Lady of Lourdes Hospital  
Mr. Paul Robinson, Former Chief Executive Officer, NEHB  
Mr. Rajpal, Consultant Surgeon, Cavan General Hospital  
Mr. Roy Cazabon, Consultant Surgeon, Monaghan General Hospital  
Mr. Tadgh O'Brien, Former Assistant Chief Executive Officer, NEHB  
Ms. Denise Flynn, CNM2, Orthopaedic Ward, Our Lady of Lourdes Hospital  
Ms. Mary Langtry, Acting Night Superintendent, Cavan General Hospital  
Ms. Sinead Kierans, Staff nurse, Our Lady of Lourdes Hospital  
Ms. Triona Mee, Night Superintendent, Our Lady of Lourdes Hospital  
Ms. Blanaid McPhillips Staff nurse, Monaghan General Hospital  
Ms. Bridget Clarke, Assistant Director of Nursing, Cavan General Hospital  
Ms. Doreen McAllister Staff nurse, Monaghan General Hospital  
Ms. Emer Clarke, High Care Unit, Monaghan General Hospital  
Ms. Francis McNally, Staff nurse, Monaghan General Hospital  
Ms. Mary Jarvis, Staff nurse, Monaghan General Hospital  
Ms. Moira McKenna, Surgical Ward, Monaghan General Hospital  
Ms. Mona Lambe, Night Superintendent, Monaghan General Hospital  
Ms. Niamh O'Neill, Staff nurse, Monaghan General Hospital  
Ms. Noreen O'Mahoney, Staff nurse, Monaghan General Hospital  
Professor Peter Gillen, Consultant Surgeon, Our Lady of Lourdes Hospital  
Professor Tanner, Director of Surgical Affairs, Royal College of Surgeons In Ireland

**Relatives of Mr Patrick Walsh R.I.P. who attended for interview**

Edward Walsh

Deirdre Walsh

Francis Walsh

Gerard Walsh

John Walsh

Maeve Callan

Marian McCaughley

Marian Walsh

### **Appendix 3b**

#### **Interviewees who submitted written statements:**

Dr. Imtiaz Hussain, Surgical SHO, Monaghan General Hospital  
Mr. Kiran Jha, Surgical SHO/Acting Registrar, Monaghan General Hospital  
Dr. Mujeeb Khan, Consultant Anaesthetist, Monaghan General Hospital  
Dr. Suhail Baloch, Anaesthetic Registrar, Monaghan Hospital  
Mr. Ashghar Ali Shaikh, Surgical Registrar, Monaghan General Hospital  
Mr. Declan Reidy, Consultant Orthopaedic Surgeon, Our Lady of Lourdes Hospital  
Mr. El-Masry, Consultant Surgeon, Our Lady of Lourdes Hospital  
Mr. Emile Aboghaly, Surgical Registrar, Cavan General Hospital  
Mr. Joseph McGrath, Consultant Surgeon, Our Lady's Hospital  
Mr. McMurray, Consultant Surgeon – Cavan General Hospital  
Mr. Omer Abdul Rahim, Surgical Registrar, Our Lady of Lourdes Hospital  
Mr. Paul McCormack, Specialist Registrar in Surgery, Our Lady of Lourdes Hospital  
Mr. Roy Cazabon, Consultant Surgeon, Monaghan General Hospital  
Ms. Denise Flynn, CNM2, Orthopaedic Ward, Our Lady of Lourdes Hospital  
Ms. Mary Langtry, Acting Night Superintendent, Cavan General Hospital  
Ms. Sinead Kierans, Staff nurse, Our Lady of Lourdes Hospital  
Ms. Triona Mee, Night Superintendent, Our Lady of Lourdes Hospital  
Ms. Blanaid McPhilips Staff nurse, Monaghan General Hospital  
Ms. Doreen Allister Staff nurse, Monaghan General Hospital  
Ms. Emer Clarke, High Care Unit, Monaghan General Hospital  
Ms. Francis McNally, Staff nurse, Monaghan General Hospital  
Ms. Mary Jarvis, Staff nurse, Monaghan General Hospital  
Ms. Moira McKenna, Surgical Ward, Monaghan General Hospital  
Ms. Mona Lambe, Night Superintendent, Monaghan General Hospital  
Ms. Niamh O'Neill, Staff nurse, Monaghan General Hospital  
Ms. Noreen O'Mahoney, Staff nurse, Monaghan General Hospital

## Appendix 4

### Documents submitted to the Independent Review team by the HSE North East Hospital Network and others.

1. A New Direction for Acute Hospital Services (1993)
2. North East Hospitals – The Next Five Years (1998)
3. **HRRI** Risk Assessment of Cavan/Monaghan Acute Hospitals Report (2001)
4. Report of Maternity Services Review Group: **Kinder Report** (2002)
5. Report on Medical Council visit to Monaghan General Hospital (2002)
6. Correspondence from RCSI regarding training recognition for Monaghan General Hospital (2002)
7. College of Anaesthetist Report regarding training recognition for Monaghan General Hospital (2002)
8. Report of the Independent review panel concerning the birth of baby Bronagh Livingstone (2002)
9. Independent Facilitation report of St. Paul Consultancy (2003)
10. Review of General Services, Trauma Orthopaedic and Accident and Emergency services: **Segrave Report** (2003)
11. Monaghan General Hospital proposal for further and future development: **Bonner Report** (2003)
12. Report into the circumstances pertaining into the death of Frances Sheridan (2004)
13. Directive from the Chief Executive Officer, North Eastern Health Board regarding the development of Joint Departments within Cavan/Monaghan Hospital Group (April 2004)
14. Guidance document from Professor W.A. Tanner, RCSI regarding joint Department of Surgery (2004)
15. Steering Group Report on implementation of 2004 directive (April 2004)
16. Progress report to the Chief Executive Officer from the Steering Group (October 2004)
17. Notification to Primary Care Services regarding bed status at Cavan General Hospital (2005)
18. Correspondence from Consultant Surgeons Cavan/Monaghan Hospital to HSE NE Acting Network Manager (September 2005)

19. Response to above from A/Network Manager to Surgeons at Cavan/ Monaghan Hospital (September 2005)
20. Directive issued from Hospital Network Manager regarding transfer arrangements for Surgical and Medical Emergencies (October 21<sup>st</sup> 2005) and subsequent directive (November 3<sup>rd</sup> 2005)
21. Document from Director of NHO and President of RCSI with recommendations to the Minister for Health & Children and the National Hospitals Office concerning Surgical Services in Cavan/Monaghan Hospital (November 22<sup>nd</sup> 2005)
22. Capita "Clinicians in Management" Review of management structures at the North Eastern Health Board Acute Hospital Groups (2002)
23. The Comhairle an nOspideal Report of the Committee on Accident & Emergency Services (2002)
24. History of North East 1971 – 2004 (2005)
25. Transfer related incidents reported at Cavan/Monaghan hospital (2005)
26. Transfer related incidents reported at Louth/Meath Hospitals (2004 & 2005)
27. RCSI report of the visit to Cavan General Hospital (2004)
28. Protocols for the Joint Department of Surgery Cavan/Monaghan (2005/2006)
29. Nursing reports on bed status from Our Lady of Lourdes Hospital and Cavan General Hospital (October 13<sup>th</sup> 2005)
30. Bed Management report from Cavan General Hospital for 2005
31. Letter from office of Liam Duffy CEO Beaumont Hospital 27 4 2006
32. Clinical records Mr P Walsh, OLOL Hospital, Drogheda and Monaghan Hospital
33. Copies of correspondence April 2004-Jan 2005, Office of Mr Finbar Lennon (Lead Surgeon, Independent Medical Advisor).

## **Appendix 5a**

27 October 2005

Mr. Pat Mc Loughlin,  
Director,  
National Hospitals Office,  
Limetree Avenue,  
Millennium Park,  
Naas,  
Co. Kildare

### **Mr. Patrick Walsh R.I.P.**

Dear Pat,

I refer to the recent death of Mr. Patrick Walsh at Monaghan Hospital and to the forthcoming external review into the circumstances surrounding Mr. Walsh's tragic death.

As discussed, the Tánaiste met with members of the Walsh family this week. A number of issues were raised in the course of the meeting which the Tánaiste has asked me to bring to your attention including:

- the family wish to be consulted on the proposed terms of reference in advance of the commencement of the review;
- the family requested that the terms of reference should cover the period from Mr. Walsh's admission to Our Lady of Lourdes Hospital, Drogheda to his death in Monaghan General Hospital;
- the family wish to meet Mr. Carey during the course of the review;
- the family wish to see an interim report in advance of the completion of Mr. Carey's review;

The Tánaiste indicated her general support for the above and advised that the issues raised would be brought to the attention of the HSE.

I would be obliged, therefore, if you would ensure that the above matters are considered and addressed by the Executive as a matter of priority.

Yours sincerely,

---

Denis O'Sullivan,  
Principal Officer.

## **Appendix 5b**

27<sup>th</sup> October 2004

Mr. Kevin Molloy  
General Manager  
Cavan/Monaghan Hospital Group  
Cavan General Hospital  
Cavan

### **RE:CAVAN/MONAGHAN HOSPITAL GROUP**

Dear Mr. Molloy

I received a fax communication this morning 27<sup>th</sup> October 2004 from Professor Arthur Tanner, Director of Surgical Affairs, Royal College of Surgeons in Ireland. This was a response to my request for clarification on the current restrictions on surgical services that should apply in both Cavan and Monaghan hospitals. As you know there has been renewed confusion at management and at clinical levels (i.e. consultant surgeons and GPs) about the current restrictions.

The College position as of now is that any advice that is necessary in this regard is within my remit as Medical Advisor to provide. As you know both Professor Tanner and I have been monitoring the situation in our separate roles and our positions are broadly similar.

In his fax communication Professor Tanner indicates that the College intend to seek an invitation to revisit Cavan General Hospital in the near future to critically appraise the teaching and training environment in the Cavan/Monaghan Hospital Group. He further states that if requested the College visitors will also look at surgical governance issues.

In the light of the above my advice is that for the present no major elective or major emergency GIT surgical operations should take place in Cavan. These cases should be transferred to Drogheda or on occasion to Dublin. My advice for some time has been that only elective minor and intermediate surgery should take place in Monaghan. Emergency cases from Monaghan should be transferred to Cavan or on occasion when major surgical intervention is required, to Drogheda. I would be grateful that in addition to providing this clarification to the surgeons on both sites that you also inform the appropriate management authorities that it will be necessary in my opinion for elective surgery in Drogheda to be restricted in order to cope with this situation.

Yours sincerely

---

F. Lennon  
Medical Advisor to  
North Eastern Health Board Management

## Appendix 5c

----- Forwarded by Kevin Molloy/NEHB on 28/10/2004 11:03 -----

**Kevin Molloy/NEHB**

28/10/2004 10:51

To Noel McMurray/NEHB, Mohamed Hilal/NEHB, A.S. Ahmed/NEHB, p  
mcaleese/NEHB, Akhtar Anjum/NEHB, Roy Cazabon/NEHB

cc CGH\_Mgt\_Team

Subject Letter from Mr Lennon to Kevin Molloy 27 October 2004

Dear Colleague

I attach a copy of a letter received from Mr Finbar Lennon advising on the appropriate level of surgical service at Cavan and at Monaghan in current circumstances. You should realise that management will expect you as consultant surgeons to heed this advice. Any variation in the advice received from Mr Lennon will be communicated to you.

Given the scrutiny that surgical services have been under in Cavan Monaghan Hospital, there is a need for medical advice received to be communicated to interested parties within and outwith the hospital. Mr Lennon's letter is being circulated to you first as a courtesy. However, you may wish to know that I will thereafter advise all staff within Cavan Monaghan Hospital of the advice that the letter contains. Arrangements will also be made to communicate Mr Lennon's advice to GPs.

Yours etc

Kevin Molloy  
General Manager  
Cavan Monaghan Hospital

## **Appendix 6**

In the interests of fair processes and procedures the reviewers were advised to seek comments from those individuals named or alluded to in this report. Following submission of a preliminary report to the HSE the individuals in list A below were written to and sent relevant copies of extracts from this preliminary report. Letters were dated 7<sup>th</sup> June 2005. An initial deadline of 15<sup>th</sup> June was complied with by most. However due to some delays in postage and in seeking legal advice this deadline was extended to 20<sup>th</sup> June for selected individuals. One single correspondence was returned to sender and the relevant individual was allowed to respond by 27<sup>th</sup> June. All responses returned were received as per timetable.

The reviewers have carefully considered all responses received and finalised this report based on these deliberations.

### **List A**

Mr. Kiran Jha, Surgical SHO Acting Registrar, Monaghan General Hospital  
Mr. Chris Lyons, Network Manager, HSE North Eastern Area  
Mr. El-Masry, Consultant Surgeon, Our Lady of Lourdes Hospital  
Mr. Emile Aboghaly, Surgical Registrar, Cavan General Hospital  
Mr. Finbar Lennon, Consultant Surgeon, Our Lady of Lourdes Hospital and Former Independent Medical Advisor to NEHB  
Mr. James Murphy, Lead Surgeon, Cavan General Hospital  
Mr. Kevin Molloy, General Manager, Cavan General Hospital  
Mr. McMurray, Consultant Surgeon – Cavan General Hospital  
Mr. Omer Abdul Rahim, Surgical Registrar, Our Lady of Lourdes Hospital  
Mr. Roy Cazabon, Consultant Surgeon, Monaghan General Hospital  
Ms. Mary Langtry, Acting Night Superintendent, Cavan General Hospital  
Ms. Mona Lambe, Night Superintendent, Monaghan General Hospital  
Professor Tanner, Director of Surgical Affairs, Royal College of Surgeons In Ireland

**Appendix 7**

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