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THE SUNDAY TIMES

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Child patients 'wrongly' put on waiting lists

Report alleges misuse of National Treatment Purchase Fund

John Mooney
Investigations Editor

An internal investigation at Children's Health Ireland (CHI) found that a consultant abused the state's waiting list system while also delaying operations for sick children up to three years.

According to the unpublished findings, the consultant breached strict HSE guidelines by referring patients he was seeing in his public practice to weekend clinics that he was operating separately.

The consultant was paid €35,800 via the state's National Treatment Purchase Fund (NTPF), which aims to cut waiting times by paying private practices to treat patients on public waiting lists. However, according to multiple sources, the 2021 inquiry found the patients selected had not waited longest, and so did not qualify for the consultant's appointments.

The children would have been treated earlier had the consultant referred them to colleagues where he worked, as is HSE protocol.

CHI was urged to report the matter to the Irish Medical Council and other state agencies but it is unclear what action was taken. The Department of Health last night confirmed it was never alerted to the report's findings.

"The [health] minister takes the concerns raised with her as a result of queries received very seriously and has asked the National Patient Safety Office to engage with CHI accordingly," said a spokeswoman for Jennifer Carroll MacNeill.

The investigation into the affair, whose existence is disclosed for the first time today, provides a damning insight into CHI. The Sunday Times is unable for legal reasons to identify the CHI hospital, the consultant or his area of expertise, but can disclose the investigation found the following:

- Alleged misuse of the government's NTPF.
- Children were on waiting lists unnecessarily and not referred to colleagues who could have treated them sooner.
- Clinically urgent cases were not prioritised.

The issue was discovered during a 2021 examination of a CHI hospital department that identified multiple issues including potential negligence and a toxic work environment where bullying was the norm. The financial irregularities were identified during a review of how the department's waiting lists were managed.

It found the consultant had made an application to the NTPF to clear a backlog of patients that needed medical appointments. It found the NTPF had been told the clinics would be held in an HSE facility when in fact they were done in a CHI hospital.

The investigation found that no efforts were made to refer the patients to other consultants or clinical teams available to treat them. Instead, the consultant sought and was paid €200 per patient, on top of costs to provide administrative staff and a healthcare assistant to see the patients.

Of the 179 patients seen, 95 per cent could have been seen by other CHI consultants. The inquiry also found those referred to the clinics in question had not waited the longest: 147 other children had endured longer waits. Patients were picked for reasons unrelated to clinical urgency or waiting time, possibly because their appointments were not complicated.

Of the 179 cases examined, 50 children required surgery but were never given a date. The consultant placed them on his own inpatient waiting list, which had a 13-month delay, even though other doctors within CHI could have seen them within six months.

The surgeries involved procedures that, under clinical guidelines, should have been performed before the children reached 12 to 18 months of age. The investigation found that had these children been put on the general waiting list when first assessed, they would have been seen two to three years earlier. Instead, they were treated only after being seen in the clinics in question, by which time many had passed the clinically recommended window for intervention.

An internal report, according to multiple sources, concluded that the decision not to refer these patients earlier was not in the best interests of the children and was potentially negligent. The consultant's actions were described as hugely questionable in terms of professional conduct and ethical standards, and contrary to the

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THE BOLD McCABE

JOSE BRETON /INPHO

Ireland captain Katie McCabe celebrates with the Uefa Women's Champions League trophy after helping Arsenal beat holders Barcelona 1-0 in the final in Lisbon yesterday. *Full story, Sport*

Minister to overhaul non-jury court trials

Jennifer Bray Political Editor

The government will move to replace the Special Criminal Court with a new permanent non-jury court, The Sunday Times has learnt.

Jim O'Callaghan, the justice minister, is expected to bring a memo to cabinet outlining plans to overhaul the Offences Against the State Act.

The act underpins the establishment of the non-jury Special Criminal Court but, as it is emergency law, it must be renewed each year. The government is expected to renew the legislation again this year but will indicate that significant changes will be made.

O'Callaghan is expected to tell ministers he believes it is appropriate to accept in principle the recommendations of a government-appointed review group, which recommended the abolition of the Offences Against the State Act.

The main recommendations of the review group centred on the consolidation of all legislation dealing with terrorist offences, and the establishment of a new standing non-jury court to replace the Special Criminal Court. This new court would try serious criminal offences when the ordinary courts are inadequate.

The Special Criminal Court handles terrorism and organised crime cases, and was previously used during the Troubles to prosecute members of the Provisional IRA. The court has also been used for gangland cases and cases involving dissident republicans.

The Offences Against the State

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NEWS

CHI consultant accused of misusing funds as juveniles faced prolonged delays for care and surgery

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principles of fair and effective waiting list management.

In 2021, the same consultant applied to the NTPF to run further clinics. At no point did he suggest patients could be seen by colleagues – a breach of the HSE's code of standards. The weekend sessions ran for five hours, with a new patient scheduled every ten minutes. The consultant was paid €200 per patient, earning €35,800.

In contrast, his CHI outpatient clinics allocated 15 minutes per new patient and were capped at 23 patients per session, although they had the support of a registrar.

At the sessions, the consultant saw between 29 and 47 patients per session – all new cases who would typically require more time for assessment, however. The investigation noted significant differences in the way the clinics in question were run compared with standard CHI operations.

Investigators concluded children were placed inappropriately on extended waiting lists, despite other treatment options being readily available.

Today's disclosure will intensify pressure on Carroll MacNeill to launch a full investigation into CHI and potential abuse of the NTPF.

The Department of Health said no notification about the matter was made under patient safety protocols, but a reference was made in a note to the CHI board at the July 2021 meeting that an internal examination was at an early stage of gathering data.

CHI said it regularly did internal reviews to ensure any issues were identified and addressed across its services. "CHI is a learning organisation and service improvements through internal reviews and clinical audits, which are an essential tool to support this, will continue to be a priority.

"A number of underlying concerns, service gaps and issues were identified in the [named service] which needed to be explored and understood in greater detail, to ensure supportive action and corrective measures could be put in place where required. This internal review report was presented and discussed at board. The recommendations were accepted, implemented and continue to be implemented," a spokeswoman said.

"The merging of processes, policies, practices and cultures presents the opportunity to make meaningful, strategic and sustainable change [at CHI]."

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Sick culture

John Mooney explores how dysfunction, potential negligence and greed at Children's Health Ireland put young patients at risk

They called them orphans. This was the term used by some hospital staff to describe a group of vulnerable children – patients effectively stranded at the Children's Health Ireland (CHI) hospital, who received substandard care long after national policy and clinical best practice dictated that they should have been moved to another hospital.

The decision wasn't medical. Behind it lies a deeper, more disturbing reality: the country's flagship children's health service is being held hostage by a toxic internal culture – one marked by professional rivalries, bullying and a failure of leadership that put patient safety at risk.

The discovery of the orphans was made during an examination of services at one CHI hospital which uncovered a catalogue of dysfunction: a consultant devising schemes to enrich himself; surgical trainees being subjected to humiliation; and children subjected to intolerable risks because of mismanaged services.

One risk assessment from 2021 gave a sub-section of a department a "red" score of 20 out of 25 – just five points from the worst possible rating.

But more than anything else, the decision to keep the findings of the investigation from the public illustrates how CHI, the body charged with overseeing Ireland's children's hospitals, has failed in its fundamental duty: to provide medical care to the country's most vulnerable patients – sick children.

WAITING LISTS FOR PROFIT

Perhaps the most damning revelation of that internal inquiry was its discovery of evidence that showed how a consultant manipulated the hospital's waiting list system to profit from weekend clinics paid for under the National Treatment Purchase Fund (NTPF).

The NTPF was established by the government to cover the cost of medical treatments for those unable to afford them and to help reduce hospital waiting lists. If a patient required urgent care or had been left on a waiting list for an inordinate amount of time, the NTPF would cover the cost of private treatment.

However, the scheme and similar funds provided by the HSE had inherent vulnerabilities: they depended on honesty.

What began as a routine examination of services at one CHI hospital in 2021 quickly evolved into something far more serious. It uncovered evidence of professional misconduct, unethical behaviour and potential negligence, all outlined in a secret report.

The investigation found the consultant appeared to have delayed the treatment of children, placing them on long waiting lists despite other doctors in the hospital being available to see them sooner.

Further investigations established the same consultant had applied to run taxpayer-funded weekend clinics with funding from the NTPF, charging €200 per patient and the cost of employing administrative staff and healthcare assistants. When he submitted the NTPF application, he did not disclose his own involvement in the clinics.

The NTPF were never told the backlog was in fact the consultant's own waiting list and the work was to be undertaken by a single consultant. When the scheme was approved for funding, the consultant earned €35,800 for just one clinic.

The story doesn't end there. One clinic organised by the consultant held across 2020 and 2021 treated 179 children; 95 per cent of these cases when examined could have been handled earlier by other CHI consultants. Of those 179 patients, 50 children required surgery.

Rather than referring them to available colleagues, the consultant placed them on his own inpatient waiting list – which had a 13-month delay – even though others in the same hospital could have operated within six months.

The procedures in question were time-sensitive, with clinical guidelines recommending they be performed before the child reached 12-18 months of age. The delay meant many children missed the optimal window for treatment. It's not known if the parents of the children were ever alerted to what happened.

According to multiple sources familiar with the affair, had the children been placed on standard waiting lists when first assessed, they would have been seen two to three years earlier.

The investigation itself concluded the failure to refer patients to available colleagues was not in the best interest of the children and was potentially negligent. The consultant's actions were described as hugely questionable in terms of ethics and professional conduct. Despite this, it remains unclear if CHI took any action against the consultant or if the matter was reported to the Irish Medical Council (IMC) or any state oversight body.

The IMC last week said that it did not comment on individual complaints, nor did it confirm whether it was in receipt of a complaint. CHI said it implemented all recommendations and was continuing to do so but did not address specific questions on whether the individual was reported to the IMC.

Nonetheless, he continued to organise and profit from these clinics. These clinics also operated under much reduced clinical standards compared with CHI's regular outpatient sessions.

The consultant saw between 29 and 47 patients per session – all new cases, each typically requiring more time for proper assessment.

A DEPARTMENT IN DISARRAY

The department under review offered a variety of specialist services to desperately sick children. One of its services, which again cannot be identified for legal reasons, failed to deliver care aligned with international standards.

A culture of professional sabotage and refusal to collaborate by the consultants left children undergoing complex operations without the multi-disciplinary support typically required for safe outcomes.

Such dysfunctional relationships played a significant part in surgeries evolving with complications and ultimately children having prolonged recoveries. The investigation concluded that such incidents would not have happened if consultants had worked together.

One consultant routinely refused to co-operate with colleagues and performed high-risk procedures single-handed – despite these procedures requiring two surgeons under international norms. On at least one occasion, according to sources, this resulted in a prolonged procedure on a neonatal patient with significant post-operative complications during the procedure and recovery.

When a review was organised to establish what had happened, the team refused to even speak to one another, choosing instead to litigate patient care decisions through back-channel correspondence.

TRAINING AND TRAUMA

The toxic environment at the hospital department wasn't limited to senior clinicians. Medical trainees told investigators they faced bullying, reputational attacks and professional sabotage.

One trainee recalled being made the scapegoat for clinical outcomes over which they had no control – all while being undermined publicly by their supervising consultant.

In another incident, a consultant allegedly encouraged a parent to lodge a formal complaint against a junior over an issue in which they had no involvement.

A consultant appears to have targeted trainees working under his supervision, suggesting they had acknowledged they couldn't hold needles properly during surgery or correctly tie knots. When the suggestions were probed, the inquiry discovered no such admissions had been made. In fact, everything the consultant said was contested.

CHAOS BEHIND CLOSED DOORS

Similar dysfunction was found in another branch of the hospital, which led to three staff resigning from one department between 2013 and 2021 due to bullying. A senior staff member described the work environment as "traumatising" to the investigation. Staff reported suffering panic attacks and stress-induced illness as a result of the internal climate.

But there were other issues. At one point, a risk assessment revealed the patient database was so poorly maintained that hundreds of children's records had to be retrospectively audited and corrected. The situation reached a crisis point which affected 400 children, resulting in their parents and GPs having to be contacted, according to another source familiar with this issue.

One consultant wrote to say the department would no longer be accepting referrals at relevant times, in defiance of CHI's own mandate to provide care for sick children.

THE FORGOTTEN CHILDREN

Children who suffer from a specific birth defect, which we cannot disclose for legal reasons, remained stranded in an outdated care model at the CHI hospital long after it was deemed clinically inappropriate. The children themselves were all born before 2008 and ended up being cared for by the hospital, although another CHI hospital is regarded as the centre of excellence for their care.

At the time of the investigation, the inquiry concluded these children were receiving suboptimal care, with no clear governance pathway for their treatment. The lack of transition to integrated care models was never explained. The failure by CHI to provide proper oversight was identified as a huge issue.

BREAKDOWN OF GOVERNANCE

The 2021 investigation revealed that professional rivalries at CHI were not just counterproductive – they were highly dangerous and potentially negligent. One case involved a dispute between two consultants over who should treat a child requiring a procedure. One consultant refused on the grounds that it wasn't their speciality – only to perform a similar procedure on another child two days later.

An email thread examined during the investigation relating to the dispute stretched for weeks, with no resolution. CHI's management failed to intervene in disputes of this nature. Internal surveys found that 89 per cent of staff believed the organisation was too slow to address poor performance. More than half described the senior leadership as "unresponsive" or "complicit in dysfunction", according to people familiar with the affair.

The investigation paints a stark picture of a hospital in crisis – one where strong personalities held undue sway over clinical decisions, governance and the day-to-day functioning of services. Instead of collaboration and accountability, CHI operated in an environment where individual egos dictated outcomes, professional rivalries obstructed care, and management failed to assert control. The result was a culture in which patient safety was compromised, staff were undermined and critical services deteriorated under the weight of dysfunction.

To address the deep-rooted issues laid bare by the investigation, Jennifer Carroll MacNeill, the health minister, and the government must now consider a full-scale overhaul of CHI's governance structures, with independent oversight, transparent accountability mechanisms, and a clear mandate to prioritise patient care over internal politics.

The health minister is already struggling to reform CHI.

On Friday she published an independent audit of pelvic osteotomies – a serious form of bone surgery – which had been performed on children with developmental dysplasia of the hip between January 2021 and December 2023.

The review focused on whether these invasive procedures were necessary in each case. The majority were found to have not met the criteria, meaning children had surgeries they didn't need. This follows another scandal where surgical springs were implanted into children at Temple Street Children's Hospital in Dublin as part of "a well-intentioned but ill-considered effort to provide an alternative approach to surgical treatment, involving a single operation, for a number of children with life-limiting conditions".

As before, policies and safety checks "were not properly applied" in treating the children affected, "resulting in the springs being used inappropriately". CHI is likely to face an avalanche of lawsuits over both scandals.

History of controversy at Children's Health Ireland

Late 2022
CHI senior management become aware of serious patient safety concerns regarding spinal surgeries performed on a number of children with spina bifida at the Temple Street hospital. The issues included poor clinical outcomes, frequent post-operative complications and infections, and two serious surgical incidents in July and September.

November 2022
The Department of Health is notified that two serious patient safety incidents had occurred in the Temple Street hospital. An internal clinical review of outcomes of complex spinal surgery for spina bifida patients at Temple Street is initiated. An external review is also commissioned by CHI.

A consultant ceases performing complex spinal surgeries on children with spina bifida.

July 2023
The external review carried out by Boston Children's Hospital looks at 17 surgeries carried out by one surgeon at Temple Street.

Both the internal and the Boston review find that one child had died and several others suffered serious post-op complications. The HSE's chief clinical officer makes an assessment that an additional, wider and externally led review was needed.

August 2023
CHI reports additional patient safety concerns regarding the use of non-CE marked spring implants in three surgeries that were performed between 2020 and 2022.

September 2023
The HSE commissions UK expert Selvadurai Nayagam to lead an external review of the paediatric orthopaedic surgical service at Temple Street. The review focuses on clinical care provided by one consultant.

Then minister for health Stephen Donnelly tells the Dail: "The surgeon involved in all the incidents ... has now stopped all clinical practice and has been referred to the Medical Council."

The Health Information and Quality Authority (HIQA) is asked to carry out a separate inquiry into the use of non-CE marked spring implants into children.

April 2025
HIQA publishes its review and finds the use of the springs was "wrong". The report highlights severe governance and oversight failures, including the absence of a committee to approve and oversee the introduction of class III medical devices. In response, Jim Browne, chair of the CHI board, resigns.

Debates in the Dail address findings from a leaked clinical audit published by The Ditch website of children's hip surgeries performed between 2021 and 2023 across CHI at Temple Street, CHI at Crumlin, and the National Orthopaedic Hospital Cappagh.

The surgeon who was suspended over the spinal surgeries was also involved in these surgeries.

May 2025
Parents raise concerns with Jennifer Carroll MacNeill, minister for health, over CHI's use of gastro buttons, typically used in the stomach, in the bladders of children. They flag that they were not informed that the buttons were being used off-label – that is, not for their intended medical purpose.

The minister commits to addressing their concerns as the families consider legal action. The full audit into hip surgeries is published and reveals that 60 per cent of surgeries examined at Temple Street and 79 per cent at Cappagh were not clinically indicated, raising concerns about unnecessary procedures and lack of oversight.

A wider review of 1,800 children who had hip surgeries from 2010 is announced.