So many red flags... yet no senior staff intervened in a system doomed to fail

By Michael O'Farrell
INVESTIGATIONS EDITOR

Shocking dossier of inaction as children in south Kerry suffered at the hands of a doctor 'almost out of control'

FOR years there were repeated red flags that vulnerable children and adolescents seeking care from the South Kerry Child and Adolescent Mental Health Services (CAMHS) team were instead being put in danger by the service they trusted to help them.

This week's Maskey Report does not hesitate to criticise the reckless and irresponsible culture of the nameless HSE executives at fault.

'Risk management… from the frontline to the Area Management level, was generally considered in terms of making the problem go away,' the report reads.

The following is a timeline of the opportunities missed – over the course of more than half a decade – to prevent this scandal.

July 2016

Junior Doctor David Kromer is appointed to the Kerry CAMHS Team A as a senior house officer – a position described in this week's HSE report as 'one level up from intern'.

Dr Kromer should have been supervised by a consultant psychiatrist. However, as he joins the team, its consultant post becomes vacant leaving him largely unsupervised.

> *'Risk from absence of a consultant is rated as maximum'*

To address the shortfall, HSE managers ask Dr Kromer to report to a consultant psychiatrist with Team B – who already has a demanding workload. The arrangement is doomed to failure.

September 2016

For historical reasons, Team A is already overstretched, undermanned and failing to meet the needs of patients.

Concerned Multi-Disciplinary Team (MDT) members write to the executive clinical director to express concern about the lack of a consultant at their meetings.

They also highlight 'the backlog of clients awaiting formal diagnosis, Mental State Examinations being overdue and the backlog of young people awaiting medication reviews.'

October 2016

MDT members express 'concerns in relation to current working conditions'.

The executive clinical director suggests 'buying in' psychiatry input as Team A's waiting lists are temporarily frozen.

Unable to manage the request to supervise Team A, the consultant psychiatrist from Team B warns the joint workload can no longer be managed.

After just eight weeks, the supervisory arrangement put in place at the time of Dr Kromer's appointment is already failing patients.

Knowing the dangers, Team B's consultant psychiatrist fills in a risk assessment form stating the risks from the absence of a consultant are the maximum possible – 25/25 on the service's risk register.

November 2016

The consultant psychiatrist from Team B again expresses concern at their inability to manage both teams.

At a management meeting, it is suggested that the teams could merge until the staffing situation is rectified. This never happens.

At this point, Team A has 33 overdue cases of children and adolescents awaiting Mental State Examinations.

January 2017

The backlog at Team A has now spiralled to 130. Management meetings continue but fail to find a solution.

May 2017

Team A's MDT notes that 'staff strain is prevalent due to the existing situation' and asks management to allow Team A only deal with emergencies for a time. The request is declined by the executive clinical director.

The MDT makes a point of highlighting the absence of any doctor at all at 12 of its last 36 meetings, meaning the team often can't proceed properly with patient care without input from a doctor or consultant.

Meanwhile, only the most complex cases being handled by Dr Kromer are being supervised.

February 2018

A locum consultant psychiatrist is temporarily appointed to Team A and begins to supervise Dr Kromer.

The locum becomes concerned that Dr Kromer is not engaging with the Irish Medical Council's Professional Competence Scheme, is isolated from the MDT and is 'micromanaging patients with medication'.

The locum informs the consultant psychiatrist from Team B of these concerns.

According to the Maskey Report: 'No effective action was evident to address them.'

July 2018

Team A, as a whole, writes to the head of service detailing 'multiple concerns about waiting lists, access to training and development for staff' and other issues including 'the issue of safety for the patients, through inadequate clinical resources and training'.

October 2018

Team A's MDT writes to the newly appointed executive clinical director to express 'serious concerns about the service'.

Issues raised included the lack of a consultant and 'clinically unsafe' practices.

At this point, the MDT stated they would no longer proceed with meetings without a medic present.

December 2018

A newly recruited consultant for Team A – who was supposed to begin work – decides not to take up the post. Team A's MDT requests an urgent meeting with the executive clinical director to ask who the clinical lead for the team is.

January 2019

A Team A patient dies by suicide. There is no suggestion the team's actions contributed to the tragedy but the team feels responsible and is distressed.

Dr Kromer emails the executive clinical director asking to be relieved of adult on-call duties citing 'workload and multiple family commitments'. His request

Whistleblower in 'Grace' case says people are still afraid to speak up

By **Michael O'Farrell**
INVESTIGATIONS EDITOR

THE whistleblower at the centre of the case involving the mistreatment of a profoundly intellectually disabled woman known as 'Grace' says the Kerry CAMHS case shows nothing has changed in the HSE.

Iain Smith told the Irish Mail on Sunday this weekend: 'Nothing has changed within the HSE since I blew the whistle to Leo Varadkar seven years ago. You can see that with the [South] Kerry CAMHS and the Naas anaesthetist scandals. People are still afraid to speak out.

'When a conscientious new worker comes in from the outside and tries to sort out the problems, they are sidelined and forced out, as happened to me. When I reviewed our services in 2013, the HSE sent my report straight to their senior civil liability solicitor.

'The Irish health services prioritise legal defence. From the contaminated blood to the cervical smear test scandals, it's always the same. It's a legacy attitude that has no place in a modern health care system.'

Mr Smith, a social worker, blew the whistle on how 'Grace' was left with a foster family for 13 years, while other foster children were removed from the same family because of allegations of sexual abuse and evidence of physical abuse and neglect.

'The Irish health service prioritises legal defence'

It comes as a review into allegations that children attending mental health services in south Kerry received inappropriate medication found that the junior doctor looking after them was prescribing out of hours by phone.

He was also giving those in care his mobile number and contacting patients on social media.

Dr David Kromer, who graduated in the Czech Republic, was also moonlighting in the beauty industry injecting Botox in beauty salons in different counties.

Details of these out-of-hours activities are contained in this week's shocking report by the UK-based consultant, Dr Sean Maskey.

At one point, in September 2019, a colleague of Dr Kromer believed he was 'almost out of control'. Yet the colleague, who had been tasked with supervising Dr Kromer from the outset, and other superiors, failed to act by raising concerns with the HSE nationally or with the Medical Council.

Instead a whistleblower who has now resigned from the HSE, Dr Ankur Sharma, was largely responsible for bringing the scandal to light.

The report, now being examined by gardaí, the Medical Council and other State agencies, also reveals how Dr Kromer was 'running a private treatment service from his home, sometimes seeing people privately up to midnight'.

Dr Kromer did not participate in the Maskey Report but has defended his treatment decisions and indicated this week that he expects to be the subject of a Medical Council inquiry.

The report, which has shocked parents, patient' representatives, politicians and regulators, assumes that Dr Kromer 'intended to help, not harm'.

But instead his practices – and the failures of HSE supervisors and managers – resulted in hundreds of children receiving 'risky' treatment. In all, 46 of those children suffered significant harm, something that the Taoiseach, Micheál Martin, a former health minister, has called 'shocking, very serious and unacceptable'.

Tánaiste Leo Varadkar, also a former health minister who cut mental health funding during his tenure, has indicated that 'compensation will be necessary'.

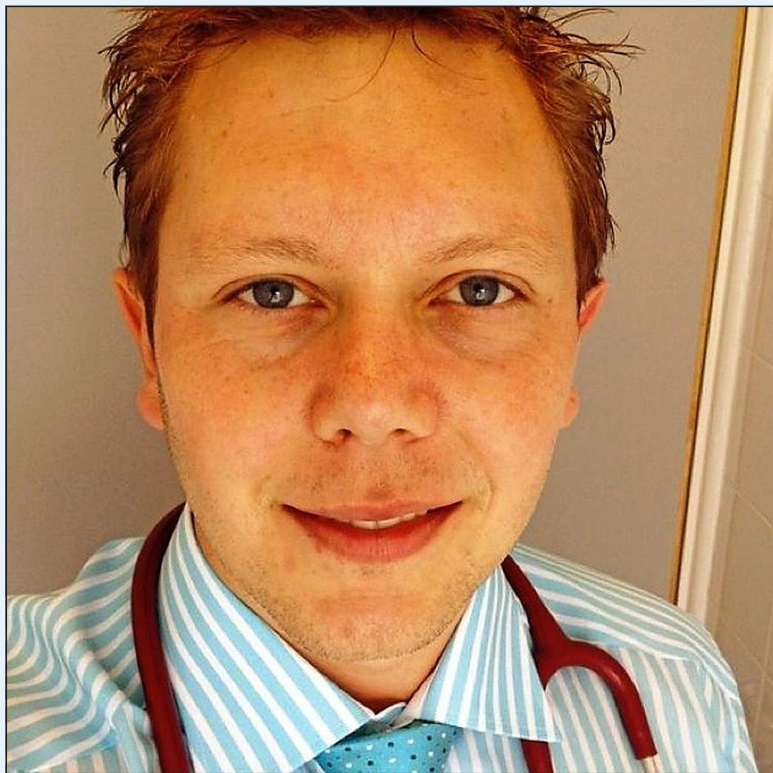
This week, the Government moved to detach repeated mental health budget cuts from blame, saying the HSE's five-year failure to hire a consultant to supervise Dr Kromer was not a 'resource issue'.

But the Maskey Report throws considerable light on the impact of years of budget cuts on mental health services.

One example of this is that the South Kerry CAMHS was a paper-based operation involving 'card files retained with metal spring clips'. Once these patient files became full, their 'integrity failed' and the contents fell out easily, potentially becoming jumbled or lost.

In addition, these paper patient files, stored in an open filing room without a lock, were often removed by clinicians without any record of their removal. Consequently many patient files were lost, resulting in patients not being followed up – a breach of data protection laws and of proper clinical guidelines.

This and the inability of the entire service to share a diary system meant administration staff did not know who was coming in for appointments and 'frequently' had to 'hunt through the building for case files that are needed urgently'.



INQUIRY: Dr David Kromer has defended his treatment decisions

is denied.

The executive clinical director sets up and chairs a new CAMHS Governance Group to 'systematically oversee the delivery and provision of an accessible, high-quality connected and responsive CAMHS service'.

The new management group consists of the executive clinical director, the CAMHS clinical director, heads of discipline, the CAMHS consultants, the director of nursing, the speech and language therapy manager, the area administrator and the quality and safety adviser.

The Maskey Report is scathing of the failure of this group to ensure Team A patients were safe.

'There is no evidence to demonstrate that this group sought to check that Team A was functioning safely and effectively,' the report reads.

'The individual managers' concern was on the performance of their staff being line-managed and there was little consideration of whole team processes.'

September 2019

A family queries the treatment of their child. Further concerns emerge about Dr Kromer 'giving patients his personal mobile number to contact him and failing to keep records of patient contacts'.

The consultant from Team B describes Dr Kromer as being 'almost out of control' while requests to Dr Kromer to alter his practices have 'little impact'.

The Maskey Report is critical of both the consultant and the executive clinical director because they 'advised', rather than directed, changes in practice to prevent further problems.' Neither took steps to approach the Medical Council.

Meanwhile, others noticed that Dr Kromer 'did not make records of his clinical work in the patient's notes' and was 'arriving several hours late for a shift' to cover a ward. The executive clinical director was alerted to these concerns but the matter was not followed up.

December 2019

The consultant from Team B and the executive clinical director both become concerned about Dr Kromer's 'practice and extensive clinical work outside the HSE' which is causing him to 'appear exhausted'.

The external work – which is against HSE rules – related to Botox injections in beauty salons in another county and a 'private treatment service' being run from Dr Kromer's home 'in which he was sometimes seeing people up to midnight'.

Dr Kromer is sent on leave but refuses to attend occupational health.

January 2020

Dr Kromer returns to work but his behaviour does not change.

March 2020

Dr Kromer says he will resign if he has to continue being on call for adult services. It is agreed he can be employed by Team A through an agency contract and he is relieved of his other on-call duties.

> *He gave Botox in beauty salons and saw private patients up to midnight*

July 2020

A new executive clinical director is appointed – the third since Dr Kromer was first hired.

The new executive is not informed of any concerns about Dr Kromer by the departing executive clinical director.

'The handover… did not include any concerns about Dr Kromer, only the lack of a consultant post for Team A,' the Mackey Report reads.

Dr Kromer is sent to work with Team B under the full-time supervision of that team's consultant psychiatrist for the first time.

It is only at this point that the consultant psychiatrist says they became 'fully aware of Dr Kromer's prescribing patterns'.

Meanwhile, Dr Kromer's replacement in Team A notices 'multiple serious concerns regarding Dr Kromer's practice' as they 'swapped teams with him'.

Dr Kromer is told not to see new patients by himself and to discuss medication changes with the consultant psychiatrist.

September 2020

Dr Kromer ceases working.

A new locum consultant, who has begun with Team A, alerts management to 'issues of clinical concern' relating to the work of Dr Kromer. A Serious Incident Management Team process is initiated and the National Clinical Lead is informed.

October 2020

As it begins its work, the Serious Incident Management Team orders a sample review of 50 cases.

As the seriousness of the situation becomes clear the team meets 31 times in the following year.

February 2021

The sample review concludes finding 'significant concerns' relating to unsafe prescribing, documentation, care planning and supervision.'

April 2021

The Mackey Report is commissioned as families begin to take legal advice.

January 2022

The Mackey Report is published sparking widespread shock, a Garda inquiry and promises of a compensation scheme.

Aside from Dr Kromer – whose identity has been revealed by the media – the identity of those responsible for these failings within the HSE remains confidential.

'The team that is currently there is not the team that was there throughout this report,' the new executive clinical director, Dr Maura Young, confirmed this week.

So far, no details have been provided about what became of those responsible.

> *Handover didn't include concerns about Dr Kromer, only the lack of a consultant post for Team A*