

# AN IRISH HEALTHCARE CRISIS: WHY CHILDREN'S HEALTH IRELAND TROUBLES ARE THE INEVITABLE CONSEQUENCES OF GENERATIONS OF NEGLECT AND UNDERINVESTMENT

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## KEY TAKEAWAYS

- Children's Health Ireland (CHI), the cornerstone of Irish paediatric healthcare, is facing an unprecedented crisis that reveals systemic failures in governance, clinical oversight, and organisational culture that directly impact patient care and safety.
- Vulnerable children with specific birth defects continued to receive substandard care long after national policy dictated they should be moved to more appropriate facilities.
- The toxic internal culture at CHI – characterised by professional rivalries, bullying, and leadership failures – has created an environment where patient safety concerns are routinely minimised or ignored.
- There are serious concerns about CHI's ability to manage the New Children's Hospital,

which is already plagued by massive cost overruns and a decade of delays.

- The CHI crisis mirrors broader problems in Irish healthcare where governance structures fail to detect and address unethical practices until they reach catastrophic levels.

## **THE BREAKING POINT: INSIDE CHILDREN'S HEALTH IRELAND'S CURRENT CRISIS**

Children's Health Ireland (CHI) stands at a precipice. What started as concerning reports of substandard care has erupted into a full-blown institutional crisis that threatens the very foundation of Irish paediatric healthcare.

The pace of revelations has been astonishing, with each new disclosure more damaging than the last. At the heart of this crisis lies a disturbing truth: the organisation charged with protecting Ireland's most vulnerable patients – sick children – has fundamentally failed in its duty of care.

The issues facing CHI aren't merely administrative missteps or isolated incidents of poor judgement. They represent a systemic breakdown in governance, clinical oversight, and organisational culture that directly impacts patient outcomes.

What makes this situation particularly alarming is that, despite CHI being a separate entity from the HSE (Health Service Executive) with its own board and management structure, it has developed toxic internal dynamics that have prioritised professional rivalries and protecting the institution over patient welfare.

As investigations continue to uncover the depth of these failures, serious questions emerge about whether CHI, in its current structure, can survive this crisis – especially as it prepares to take over the New Children's Hospital.

The stakes couldn't be higher; without appropriate review and reform, these issues will

continue to grow and undoubtedly bring the Irish paediatric healthcare system to its knees.

### Children Left Behind: The "Orphans" of CHI

"Orphans." This was the callous term used by some hospital staff to describe a group of vulnerable children effectively stranded at CHI facilities. These patients, born before 2008 with a specific birth defect, received demonstrably substandard care in an inappropriate facility long after national policy and clinical best practice dictated they should be moved to a centre of excellence.

The story of these "orphaned" patients reveals how the Irish healthcare system and CHI allowed children to fall through administrative cracks, with devastating consequences for their development and quality of life.

Internal reports indicate these children receive suboptimal care with no clear governance pathway for their long-term treatment. The lack of transition to integrated care models was never adequately explained, leaving these vulnerable patients in a dangerous healthcare limbo where proper treatment protocols aren't followed.

Perhaps most disturbing is how long this situation has been allowed to persist. While medical professionals within the system continue to raise concerns, the failure by CHI to provide proper oversight has been identified as a massive governance issue.

These children have become victims not just of their medical conditions but of an institutional indifference that prioritises organisational convenience over their wellbeing and development.

### Patient Safety Concerns That Cannot Be Ignored

The issues within CHI extend far beyond administrative inefficiencies into the realm of direct

patient harm.

A recent audit has revealed that a staggering number of surgeries for hip dysplasia carried out between 2021 and 2023 have been deemed “unnecessary”, with over 500 children being recalled for review and further case reviews pending, suggesting this number will only increase over time.

In April 2025, the Health Information and Quality Authority (HIQA) published an independent review that revealed that three children underwent surgical procedures for scoliosis that involved the implantation of “wrong” surgical springs that did not receive ethical approval and may corrode over time.

These weren't isolated incidents but rather part of a pattern that suggests systematic failures in clinical governance and oversight mechanisms designed to protect patients.

Whistleblowers within the organisation have described a culture where raising patient safety concerns often led to professional marginalisation rather than corrective action. Those who attempted to advocate for better standards of care found themselves labelled as troublemakers, while serious safety issues remained unaddressed.

This toxic environment has created a perfect storm where problems fester beneath the surface until they become too severe to ignore.

The failure to establish clear clinical guidelines and enforce proper oversight has had direct consequences for patients. In some cases, children have endured years of inappropriate or inadequate treatment, with their conditions worsening while they remained trapped in a system that wasn't designed to serve their needs.

These failures aren't just administrative oversights – they are profound breaches of the fundamental medical principle: first, do no harm.

## **IRISH HEALTHCARE CRISIS: THE DECADES OF NEGLECT THAT LED US HERE**

The current crisis at Children's Health Ireland didn't materialise overnight. It represents the culmination of decades of systemic neglect, underinvestment, and missed opportunities in the Irish paediatric healthcare system.

Since the 1990s, successive governments have acknowledged the need for comprehensive reform in paediatric healthcare while consistently failing to allocate the necessary resources or political capital to make meaningful changes. This pattern of neglect has created fertile ground for the current crisis.

When resources are perpetually scarce, corners get cut, oversight mechanisms weaken, and institutional cultures develop that prioritise survival over excellence. The chronic underfunding of the Irish healthcare system has created an environment where administrators are focused on keeping services running at minimal levels rather than building robust systems of governance and quality assurance.

Perhaps most damaging has been the stop-start approach to reform, with ambitious plans announced only to be scaled back or abandoned with changes in political leadership. This inconsistency has prevented the development of coherent, long-term strategies for Irish healthcare services, leaving organisations like CHI to navigate complex challenges without adequate support or clear direction from government and other health authorities.

### **Broken Promises: The Long History of Underfunding in Irish Healthcare**

The financial neglect of Irish paediatric healthcare has been both profound and persistent. Despite Ireland experiencing periods of extraordinary economic growth, paediatric healthcare has remained chronically underfunded compared to international benchmarks.

While politicians have repeatedly promised world-class healthcare for children, the budgetary

allocations have told a different story, with paediatric healthcare receiving proportionally less funding than adult services despite the specialised needs and long-term benefits of early intervention.

This underfunding has manifested in multiple ways that directly impact patient care. Staffing shortages are endemic, with paediatric specialists carrying unsustainable caseloads that compromise their ability to provide optimal care. Infrastructure has deteriorated, with children receiving treatment in facilities that fail to meet modern standards for infection control, privacy, and family-centred care.

Perhaps most critically, the resources needed for proper governance and quality assurance – including data systems, audit capabilities, and oversight mechanisms – have been consistently deprioritised in favor of keeping basic services running.

The consequences of this financial neglect extend far beyond the balance sheet. When systems operate in perpetual crisis mode due to resource constraints, protocols get bypassed, advancements in care and treatment are not achieved, and the organisational culture shifts from excellence to mere survival.

This creates precisely the conditions in which serious failures in governance and patient safety can take root and produce devastating and far-reaching consequences.

### Political Priorities and How Irish Paediatric Healthcare Fell Through the Cracks

Irish paediatric healthcare has suffered from a persistent problem in political systems worldwide: children don't vote.

Despite widespread public support for improving paediatric services, political capital has consistently flowed toward healthcare initiatives that deliver more immediate and visible returns for adult voters. The political calculus has repeatedly favoured addressing adult

waiting lists, elder care, and high-profile adult specialties over the less visible but equally critical needs of paediatric medicine.

This political dynamic has resulted in paediatric healthcare being treated as an afterthought in broader Irish healthcare policies rather than as a foundational investment in the nation's future.

The lack of sustained political championing has meant that paediatric reform initiatives often lose momentum when they encounter inevitable bureaucratic or financial obstacles. Without powerful advocates consistently fighting for their interests, Irish healthcare organisations like CHI have been left to navigate complex challenges with insufficient political support.

## **THE NEW CHILDREN'S HOSPITAL NIGHTMARE**

The saga of the New Children's Hospital stands as a perfect metaphor for everything wrong with Ireland's approach to paediatric healthcare.

What began as an ambitious vision to create a world-class paediatric facility has devolved into a cautionary tale of mismanagement, cost overruns, and delays. Originally estimated at €650 million in 2012, the project's price tag has ballooned to over €2 billion, making it one of the most expensive hospitals ever built on a per-bed basis worldwide – and costs continue to rise.

Beyond the financial fiasco lies a more troubling question: will this enormously expensive facility inherit the same dysfunctional governance structures and toxic cultures that have plagued CHI?

There are growing concerns about CHI's ability to effectively manage this complex new hospital when it can't properly govern its existing facilities. The prospect of transplanting current organisational problems into a shiny new building represents a potential nightmare scenario for Irish paediatric healthcare.

Even more concerning is the timing. CHI is scheduled to take over the new hospital when it finally opens to patients, potentially as soon as next year.

This timeline means that an organisation in the midst of an existential crisis, with fundamental questions about its leadership, governance, and clinical oversight unresolved, will be tasked with managing the largest and most complex healthcare transition in the country's history.

The implications for patient safety during this transition period are profoundly worrying.

### €2+ Billion and Counting: The Financial Disaster

The financial story of the New Children's Hospital represents a catastrophic failure of project governance and oversight. There has been a 300% increase in cost over initial projections, making it among the most expensive hospitals ever built worldwide on a per-bed basis.

For perspective, similar paediatric facilities in other European countries have been delivered for a fraction of this cost.

The roots of this financial disaster lie in poor initial planning, inadequate cost controls, and a failure to properly scope the project before breaking ground.

Crucially, the governance mechanisms that should have provided early warning of cost overruns either failed entirely or were deliberately circumvented. Audit reports have identified a pattern of optimistic underestimation of costs followed by incremental escalations that were presented as unavoidable once the project was too far advanced to reconsider fundamental aspects of the design or location.

The financial implications extend far beyond the hospital itself. Every euro spent on cost overruns represents money unavailable for other critical healthcare needs, including the very

systems that might prevent future CHI crises.

The opportunity cost of this financial mismanagement is measured not just in money but in healthcare services not delivered and reforms not implemented across the entire paediatric healthcare system.

### A Decade of Delays: Why the New Hospital Still Isn't Open

The timeline of the New Children's Hospital has become a study in perpetual postponement. Originally scheduled to open in 2016, the facility now has a tentative opening date of 2026, representing a decade's delay on top of a 300% cost increase.

These delays have meant that generations of children have been denied access to modern healthcare facilities, instead receiving treatment in outdated hospitals that fail to meet contemporary standards for paediatric care, infection control, and family support.

The causes of these delays mirror the governance problems evident throughout the CHI system: poor initial planning, inadequate risk management, fragmented decision-making processes, and a failure to maintain clear lines of accountability.

Construction delays have been compounded by disputes between contractors and the development board, changes in specifications, and bureaucratic paralysis when problems inevitably arise.

Throughout this process, the needs of children and families have consistently taken a back seat to contractual disputes, political considerations, and institutional finger-pointing.

### Will the New Hospital Inherit CHI's Problems?

The most pressing question now facing Irish paediatric healthcare services is whether the

new hospital, despite its modern facilities and equipment, will inherit the dysfunctional governance structures and toxic cultures that have undermined CHI.

There is mounting evidence that, without fundamental reform, the same organisational pathologies will simply be transplanted into a more expensive setting. Internal assessments have identified critical gaps in CHI's readiness to manage the transition to the new facility, including inadequate planning for organisational change management, insufficient integration of clinical services, and persistent leadership vacuums in key departments.

Healthcare experts have consistently warned that new buildings don't solve cultural problems - and may actually exacerbate them if the transition process isn't managed effectively.

The complex logistics of moving services, staff, and patients to the new facility require precisely the kind of competent governance and clear leadership that has been notably absent from CHI in recent years. Without addressing these fundamental organisational issues before the transition, there is a serious risk that the new hospital will inherit all of CHI's dysfunction while adding new layers of complexity and cost.

## **PROFIT OVER PATIENTS: DISTURBING ETHICAL VIOLATIONS REVEALED**

Perhaps the most disturbing aspect of the CHI crisis has been the emergence of evidence suggesting that commercial considerations have sometimes trumped patient welfare in clinical decision-making.

Investigations have uncovered troubling patterns where financial incentives appeared to influence treatment decisions, waiting list management, and resource allocation. These ethical breaches represent a fundamental betrayal of the trust placed in Irish healthcare institutions to prioritise patient welfare above all other considerations.

The root causes of these ethical failures appear to lie in inadequate oversight mechanisms,

conflicts of interest that weren't properly managed, and a governance culture that failed to establish clear ethical boundaries.

When financial pressures mounted and resources became scarce, the systems that should have protected vulnerable patients from commercial considerations proved woefully inadequate. In some cases, the very metrics designed to measure performance became perverse incentives that encouraged manipulation and gaming of the system at patients' expense.

Most concerning has been the apparent reluctance of CHI leadership to confront these ethical failures directly, with investigations often delayed, limited in scope, or conducted without sufficient independence.

This pattern suggests an organisational culture more concerned with protecting institutional reputation than addressing the root causes of ethical breaches – even when children's welfare was at stake.

### Waiting List Manipulation for Personal Gain

One of the most extreme and troubling aspects of these commercial considerations is emerging evidence of waiting list manipulation that appears to have benefited certain consultants financially. Investigations have uncovered patterns where patients were selectively prioritised based not on clinical need but on factors that maximised revenue for private practice.

In some cases, children with less urgent conditions but private insurance were seen ahead of public patients with more serious conditions. This manipulation created a two-tier system within what should have been an equitable public healthcare institution.

The mechanisms of this manipulation were sophisticated and often difficult to detect through

standard auditing procedures. Patients would be moved between different waiting lists, administrative categories would be changed, and in some instances, records were altered to obscure the true waiting time for treatment.

What makes this particularly hard to stomach is that every manipulation that advanced one child unfairly meant another child – often with greater clinical need – waited longer for essential care.

The governance failures that have allowed this situation to develop include inadequate oversight of consultant activities, conflicts of interest that aren't properly recognised or managed, and information systems that lacked transparency. When whistleblowers attempt to highlight these issues, they often face institutional resistance rather than support for addressing what were clear ethical violations.

### Unapproved Surgical Devices and Experimental Techniques

Further investigations into CHI practices have revealed instances where unapproved surgical devices and experimental techniques were used on children, without proper ethical approval or parental consent.

Some procedures were performed using devices that hadn't completed the full regulatory approval process or were being used in ways not specifically authorised by regulatory authorities. This represents a fundamental breach of medical ethics and patient safety protocols.

The justification often offered for these practices was that they represented "innovation" that could benefit patients, but proper safeguards to distinguish between formal clinical research (which requires rigorous ethical oversight) and ad hoc experimentation were frequently bypassed.

In some cases, procedures were performed by clinicians who lacked specific training on new devices or techniques, creating additional risks for vulnerable paediatric patients.

Most disturbing was the discovery that adverse outcomes from these unapproved approaches weren't consistently reported or investigated, creating a dangerous information vacuum where complications could be dismissed as isolated incidents rather than recognised as a pattern indicating systematic problems.

The failure of CHI's clinical governance systems to prevent these practices highlights how deeply compromised the organisation's safety culture has become.

### How Children Waited Years While Consultants Profited

The human cost of CHI's governance failures should be measured in childhoods disrupted by unnecessarily prolonged suffering.

Documents reviewed during investigations reveal cases where children waited years for treatments that should have been provided within months, with devastating consequences for their development, education, and quality of life.

While these children suffered on waiting lists, some consultants appeared to be maximising private practice revenue through a system that incentivised maintaining rather than reducing public waiting lists.

The perverse incentives created by Irish healthcare's mixed public-private services became particularly toxic within CHI's already compromised governance structure. The longer public waiting lists grew, the more desperate families became, with many taking on significant financial hardship to access private care - sometimes from the very same consultants who oversaw the public waiting lists.

This created a direct financial incentive to maintain lengthy public waiting times, with each family forced into the private system representing additional revenue.

What makes this situation particularly heartbreaking is that many of the children who suffered most were from families who couldn't afford private alternatives. These families watched as their children's conditions worsened while they remained trapped in a system that wasn't working in their best interests.

The psychological impact on parents - knowing their child needed care they couldn't access - represents an unmeasured but profound additional harm inflicted by these systematic failures.

## **THE GOVERNANCE FAILURES THAT ENABLED CRISIS**

At the heart of CHI's failures lies a governance structure that proved fundamentally inadequate for its purpose.

Despite being established as a separate entity from the HSE with its own board and management, CHI developed governance mechanisms that repeatedly failed to detect serious problems, address concerns raised by staff, or maintain basic standards of transparency and accountability.

These weren't merely technical shortcomings but represented a comprehensive breakdown in the systems designed to protect patient safety and maintain ethical standards.

The governance failures extended across multiple levels, from clinical oversight to board effectiveness to regulatory supervision. Internal audits were either not conducted with sufficient rigour or their findings were systematically downplayed when they identified serious problems.

Risk management systems that should have flagged emerging issues were either bypassed

or manipulated to present a more favorable picture than reality warranted. Perhaps most critically, the lines of accountability became so blurred that when problems did emerge, responsibility could be endlessly diffused rather than clearly assigned.

What makes these governance failures particularly concerning is that they occurred within an organisation specifically created to provide better, more integrated care for children. The very reforms that were supposed to improve Irish paediatric healthcare instead created an accountability vacuum where the worst elements of both public and private healthcare systems could flourish unchecked.

### Toxic Culture: Bullying and Professional Rivalries

Beneath the structural governance failures at CHI lies a toxic organisational culture characterised by professional rivalries, bullying, and leadership failures that puts patient safety at risk. Multiple staff surveys and confidential interviews conducted during investigations revealed an environment where raising concerns about patient care often led to professional marginalisation or outright harassment.

This culture of fear has silenced many healthcare professionals who might otherwise have spoken up when they witnessed substandard practices.

The professional rivalries within CHI took on particularly destructive forms, with competing departments sometimes prioritising territorial disputes over patient needs. Resources that should have been allocated based on clinical priorities instead became pawns in ongoing power struggles between different specialties and hospitals under the CHI umbrella.

These rivalries were exacerbated by a leadership structure that failed to enforce clear standards or hold senior staff accountable for behaviour that undermined the organisation's mission.

Perhaps most damaging was how this toxic culture systematically drove away talented healthcare professionals who refused to compromise their ethical standards or who found themselves unable to cope in this toxic environment. The resulting brain drain has further weakened CHI's ability to provide quality care, creating a downward spiral where deteriorating standards led to the departure of those most committed to excellence, which has in turn accelerated the decline in the quality of care.

### Leadership Breakdown at Every Level

The failures at CHI reflect a comprehensive breakdown in leadership at every level of the organisation. From frontline clinical leaders to senior executives to board members, those charged with maintaining standards and addressing problems have systematically failed to fulfill their responsibilities.

Following the identification of issues, the response has often been to minimise their significance, delay investigation, or engage in superficial reforms that failed to address root causes.

This leadership vacuum created conditions where individuals who were willing to cut corners or prioritise personal interests over patient welfare could operate with impunity. The absence of clear consequences for ethical breaches or substandard care sent a powerful message throughout the organisation that such behaviour would be tolerated.

Meanwhile, those who attempted to uphold higher standards often found themselves isolated and unsupported, creating a perverse incentive structure that rewarded compliance with dysfunctional norms rather than commitment to excellence.

What makes this leadership failure particularly inexcusable is that CHI was established specifically to create stronger, more accountable leadership for Irish paediatric healthcare. Instead, the complex structure created multiple layers where responsibility could be

endlessly diffused and nobody could be held accountable for systemic failures.

The resulting leadership vacuum allowed problems to fester until they reached crisis proportions.

### Why Investigations Were Hidden From Public View

There has been a systematic effort to shield internal CHI investigations from public scrutiny. Documents reveal a pattern where concerns about reputation management consistently trumped transparency, with findings of serious failures repeatedly classified as confidential or diluted in public reporting.

This lack of transparency prevented early detection of systematic problems and denied parents crucial information about the quality of care their children were receiving. This situation highlights the need for accountability and transparency at every level of the Irish healthcare system.

The justifications offered for this secrecy have ranged from legal concerns about liability to claims that public disclosure might undermine confidence in paediatric healthcare.

Yet the consequence of this approach was to create an accountability vacuum where serious problems could persist for years without effective intervention. By the time issues became too severe to contain, the harm to children and families was already extensive and often irreversible.

This culture of secrecy extended to relationships with regulatory bodies like HIQA, with evidence suggesting that CHI sometimes provided incomplete or misleading information during inspections. The resulting regulatory failures meant that external safeguards that should have protected children were effectively neutralised, leaving vulnerable patients without the protections they deserved.

## **THE REAL-WORLD IMPACT ON FAMILIES**

Behind every statistic and system failure in the CHI crisis lies a child and family whose lives have been profoundly affected. Parents have described watching helplessly as their children's conditions deteriorated while they remained trapped on waiting lists, unable to access treatments that might have prevented permanent harm.

The psychological toll on families has been enormous, with many parents developing anxiety, depression, and post-traumatic stress as they battled a system that seemed designed to obstruct rather than facilitate their children's care.

Particularly devastating has been the impact on children with complex needs, who often require coordinated care across multiple specialties.

The fragmented nature of services within CHI meant that these vulnerable children frequently fell through administrative cracks, with each department addressing isolated aspects of their care without effective coordination. Parents became de facto case managers, forced to navigate a byzantine system while simultaneously caring for seriously ill children.

The financial impact on families has also been severe.

Many parents have been forced to reduce working hours or leave employment entirely to advocate for their children and provide care that the system failed to deliver. Others have incurred substantial debt to access private treatment when public services proved inadequate.

These financial pressures have created additional stresses for families already struggling with the emotional burden of caring for sick children.

Extended Suffering: Children Waiting Years for Treatment

The human toll of CHI's systematic failures is most visible in the stories of children who have waited years for treatments that should have been provided within weeks or months. These aren't merely inconvenient delays but periods of extended suffering that have profound developmental consequences.

For a child with a painful orthopaedic condition, a two-year wait doesn't just mean discomfort - it can result in permanent physical limitations that might have been prevented with timely intervention.

Even more devastating has been the impact on children with conditions affecting cognitive or social development. Delays in addressing these issues during critical developmental windows can have lifelong consequences that no subsequent intervention can fully remediate.

The inequity in how these delays affect different families is particularly troubling. Children from families with financial resources or strong advocacy skills are more likely to navigate around system failures through private care or by leveraging personal connections.

Meanwhile, the most vulnerable children - those from disadvantaged backgrounds or with parents less equipped to challenge the system - have often experienced the longest delays and worst outcomes, exacerbating existing social inequalities.

### Financial Burden on Already Struggling Families

The financial impact of CHI's failures on families has been severe and multifaceted. Many parents have been forced to reduce working hours or leave employment entirely to coordinate their children's fragmented care or provide services that the system failed to deliver.

This loss of income has come precisely when families face additional expenses related to their children's conditions, creating financial pressure that has pushed many into serious

hardship or debt.

For families who've chosen to access private care when public services proved inadequate, the financial consequences have often been even more severe. Many have depleted savings, remortgaged homes, or incurred substantial credit card debt to pay for treatments that should have been provided through the public system.

These financial sacrifices represent a hidden cost of CHI's failures - one borne not by the institution that failed in its duty but by the families least able to afford additional burdens.

Perhaps most troubling has been how these financial pressures have forced impossible choices on parents. Families have described agonising decisions between paying for private treatment to address their child's immediate suffering versus maintaining financial stability for the family's long-term welfare.

No parent should face choosing between their child's health and their family's financial security, yet CHI's failures have forced precisely this dilemma on countless Irish families.

## **INTERNATIONAL COMPARISONS: HOW IRELAND FALLS SHORT**

The problems at CHI appear even more stark when compared with paediatric healthcare systems in other developed countries. Countries with similar or even lower per capita healthcare spending have consistently achieved better outcomes, shorter waiting times, and more integrated care for children with complex needs.

These international comparisons suggest that Ireland's failures stem not primarily from resource constraints but from fundamental problems in how those resources are allocated, governed, and accountable.

Particularly instructive are comparisons with Scandinavian countries, which have developed

robust integrated care models that coordinate services across medical, educational, and social domains. These systems are built around clear governance structures, transparent performance metrics, and strong accountability mechanisms that prevent the kind of systemic failures evident at CHI.

Most importantly, they've developed cultures where raising concerns about patient safety or resource allocation is encouraged rather than punished – creating environments where problems are identified and addressed before they become crises.

Even within the UK – a system facing its own significant challenges – the governance structures for children's hospitals have proven more robust than CHI's. Organisations like Great Ormond Street Hospital have demonstrated that it's possible to maintain world-class paediatric care with strong clinical governance, transparent performance reporting, and a culture that prioritises continuous improvement over institutional protection.

These examples show that CHI's failures weren't inevitable but rather the result of specific governance choices that could – and should – have been made differently.

### Standards of Care in Other European Countries

The disparity between CHI's performance and paediatric healthcare standards across Europe is both striking and instructive.

Countries like Sweden, Denmark, and the Netherlands have established comprehensive standards for paediatric care that are rigorously monitored and enforced through transparent reporting systems. These standards cover not just clinical outcomes but also waiting times, care coordination for complex cases, and family involvement in treatment decisions – precisely the areas where CHI has most seriously failed.

European leaders in paediatric care have also developed sophisticated approaches to

managing the transition from child to adult services – another area where CHI's "orphaned" patients reveal systematic failures.

These transition protocols ensure that vulnerable young people with ongoing healthcare needs don't fall through cracks in the system during this critical period. By contrast, CHI has allowed children to remain in inappropriate care settings without clear pathways to more suitable services.

Perhaps most relevant to CHI's current crisis has been how other European systems have addressed the potential conflicts between public and private healthcare provision.

Countries like France and Germany have developed regulatory frameworks that maintain clear boundaries between public and private practice, preventing the kinds of conflicts of interest that appear to have compromised care at CHI. These examples demonstrate that mixed healthcare systems can function effectively – but only with robust governance mechanisms that CHI conspicuously lacked.

### Healthcare Funding Models That Actually Work

CHI needs a funding model that aligns incentives with patient outcomes, not institutional convenience.

Several European countries have implemented activity-based funding systems for paediatric care that tie financial resources directly to the volume and complexity of cases treated. This approach creates direct incentives to reduce waiting lists and improve efficiency – in stark contrast to the perverse incentives evident in CHI's model where maintained waiting lists could actually benefit certain stakeholders.

Equally important has been how leading healthcare systems ring-fence funding for quality assurance, clinical governance, and staff development. These critical functions – often the

first casualties of budget constraints – receive protected funding that can't be diverted to other purposes.

This approach recognises that effective governance isn't an optional luxury but a fundamental requirement for safe, effective care. CHI's apparent willingness to compromise on these functions to maintain service levels represents a false economy that ultimately increased both human and financial costs.

The most successful paediatric funding models also incorporate specific provisions for complex cases and vulnerable populations – precisely the patients who appear to have been most neglected in CHI's system. By allocating additional resources to these high-need groups and establishing clear accountability for their outcomes, these systems prevent the development of “orphaned” patient populations like those identified at CHI.

These international examples demonstrate that with proper funding structures and accountability mechanisms, the failures evident at CHI could have been prevented.

## **FIXING A BROKEN SYSTEM: WHAT NEEDS TO CHANGE**

The scale and severity of CHI's failures demand comprehensive reform rather than incremental adjustments.

Any meaningful solution must address not just the specific incidents that have come to light but the underlying governance structures, cultural dynamics, and incentive systems that allowed these failures to develop and persist. Fundamental changes are required at multiple levels – from frontline clinical practice to board governance to regulatory oversight.

Patient safety needs to be the non-negotiable priority in all decision-making. This means creating governance structures where raising concerns is rewarded, not punished; where transparency is valued over reputation management; and where accountability is clear and unavoidable. The cultural transformation required is substantial but essential – without it,

structural changes alone will not be enough.

Equally important is addressing the perverse incentives created by Irish healthcare's mixed public-private model.

The conflicts of interest that appear to have compromised care at CHI must be eliminated through clear separation between public and private practice, transparent waiting list management, and governance mechanisms that prevent resource allocation based on anything other than clinical need.

These changes will face resistance from those who have benefited from the current system, but they are essential to restore trust and ensure equal and appropriate care for all children.

#### Immediate Accountability Measures Needed

The first step toward reform is establishing clear accountability for past failures and creating mechanisms to prevent them from happening again.

This requires not just identifying individual responsibility where appropriate, but also addressing the systemic factors that enable problematic behaviours to continue unchecked. Independent external oversight of CHI's operations is essential during this transition period, with transparent reporting of findings and clear consequences for non-compliance with required changes.

Waiting list management requires particular attention and immediate reform. All waiting lists should be subject to independent audit, with standardised protocols for prioritisation based solely on clinical need.

These audits should be publicly reported in accessible formats that allow families to understand their child's position and expected timeframe for treatment. Any anomalies or

deviations from clinical prioritisation should trigger automatic investigation by independent reviewers.

Perhaps most urgently, CHI needs to protect whistleblowers and encourage staff to report concerns without fear of reprisal.

This means not just formal policies but actual cultural change where raising patient safety issues is seen as a professional obligation rather than an act of disloyalty. Without these protections, the same dynamics that silenced concerns in the past will continue to prevent early identification of emerging problems.

#### Structural Reforms to Prevent Further Abuse

Beyond immediate accountability measures, CHI requires fundamental structural reforms to prevent future abuses. The governance structure must be redesigned to eliminate the accountability gaps that allowed serious problems to develop undetected.

This means clearer lines of responsibility, more transparent reporting relationships, and governance mechanisms that can't be circumvented by powerful individuals or departments. Clinical governance requires particular attention, with standardised protocols for reviewing outcomes, investigating adverse events, and implementing improvements based on identified shortcomings.

The relationship between CHI and regulatory bodies like HIQA (Health Information and Quality Authority) must also be fundamentally reconfigured. Regulatory oversight should be strengthened with more frequent unannounced inspections, broader powers to access records and interview staff, and meaningful consequences for non-compliance with standards.

Most importantly, the culture of regulatory engagement must shift from minimal compliance

to genuine commitment to continuous improvement.

The structural reforms must also address the fragmentation of care that has proven particularly damaging for children with complex needs.

Integrated care pathways should be established with clear responsibility for coordination, seamless transitions between different services, and accountability for overall outcomes rather than just isolated interventions. These pathways should include defined protocols for transitioning patients to adult services, preventing the development of future “orphaned” patient populations.

### Funding Requirements for Proper Paediatric Healthcare

Meaningful reform of Irish paediatric healthcare requires not just structural and cultural changes but also appropriate financial resources.

While throwing money at a dysfunctional system won't solve underlying problems, even the best-designed governance structures can't function effectively without adequate funding. The resources required include not just direct clinical services but also the oversight mechanisms, information systems, and quality assurance processes essential for safe, effective care.

Particular attention must be paid to funding the transition to the New Children's Hospital. This complex process requires dedicated resources for service redesign, staff training, system integration, and comprehensive risk management. Without these investments, there is a serious danger that existing problems will simply be transferred to the new facility, undermining its potential to transform Irish paediatric healthcare.

Perhaps most importantly, funding models must be redesigned to align financial incentives with desired outcomes. This means activity-based funding that rewards reducing waiting times and improving efficiency, protected resources for clinical governance and quality

assurance, and financial penalties for preventable adverse events or persistent quality failures. By making financial flows contingent on performance, these models can reinforce rather than undermine the cultural and structural changes required for genuine reform.

## **WHAT THIS MEANS FOR YOUR CHILD'S CARE**

For parents navigating the Irish paediatric healthcare system, the revelations about CHI create understandable anxiety about the quality and safety of their children's care. While systemic reforms will take time to implement fully, there are immediate steps families can take to protect their children's interests and ensure they receive appropriate treatment.

Understanding how the system works – including its limitations and potential pitfalls – is the first step toward effective advocacy. Additionally, learning about strong leadership can empower parents to advocate more effectively for their children's healthcare needs.

It's important to recognise that, despite the systematic failures identified, many dedicated healthcare professionals within CHI continue to provide excellent care under difficult circumstances. Building collaborative relationships with these professionals – based on mutual respect and shared commitment to your child's welfare – can significantly improve your family's experience and outcomes.

At the same time, maintaining vigilant oversight of your child's treatment plan and being prepared to ask difficult questions when necessary is essential.

### **Warning Signs to Watch For**

Informed parents are their children's best advocates, and recognising potential red flags in care can prevent serious problems.

Be concerned if you encounter unexplained delays in treatment without clear clinical justification or if your child is repeatedly rescheduled without apparent reason. These may

indicate waiting list or resource allocation problems that require further investigation.

Another warning sign is fragmented communication between different specialists involved in your child's care.

If you find yourself repeatedly explaining your child's condition to different providers who seem unaware of each other's involvement, this suggests poor care coordination that could compromise treatment effectiveness. Similarly, if you receive contradictory information from different providers without explanation of the discrepancies, this may indicate governance problems within the treatment team.

Perhaps most critically, be alert to defensive responses when you raise concerns about your child's care.

If questions about treatment plans, waiting times, or unexplained symptoms are met with dismissal rather than engagement, this may indicate deeper systemic problems. Healthcare professionals working within effective governance structures welcome parental involvement and questions – defensive or evasive responses often signal environments where raising concerns is discouraged.

### Your Rights as a Parent in the Irish Healthcare System

Parents often feel disempowered when navigating complex healthcare systems, but understanding your legal and ethical rights can provide crucial leverage.

You have the right to be fully informed about your child's condition, treatment options, expected outcomes, and potential risks – in language you can understand. This includes the right to know why particular approaches are recommended, what alternatives exist, and the evidence supporting different options.

Perhaps most importantly, you have the right to be treated with respect as an essential partner in your child's care.

This includes having your observations and concerns taken seriously, being included in decision-making processes, and receiving timely responses to questions. When healthcare providers fail to respect these rights, you have legitimate grounds for formal complaints through established channels - including escalation to regulatory bodies if necessary.

### How to Advocate When the System Fails

Effective advocacy begins with documented, fact-based communication. Keep detailed records of all interactions with healthcare providers, including dates, names, what was discussed, and any commitments made. When raising concerns, focus on specific issues rather than general complaints, and whenever possible, frame your advocacy in terms of your child's clinical needs rather than administrative convenience or personal frustration.

Understanding the escalation pathways within Irish healthcare systems is crucial.

Start by addressing concerns directly with frontline providers, then progress systematically through department managers, hospital administration, and ultimately to CHI leadership if necessary. At each stage, keep written records of communications and allow reasonable time for response before escalating further.

Remember that patient advocacy services exist in most hospitals and can provide valuable support in navigating these processes. If internal advocacy proves ineffective, external options may become necessary. These include formal complaints to regulatory bodies like HIQA, engagement with patient advocacy organisations, and in some cases, legal action.

Throughout this process, connecting with other families facing similar challenges can provide both emotional support and practical strategies for effective advocacy.

## FREQUENTLY ASKED QUESTIONS

The complexity of the CHI crisis has generated numerous questions from concerned parents, healthcare professionals, and the general public. These frequently asked questions address the most common concerns about what happened, who's responsible, and what happens next. Understanding these issues is essential for anyone navigating the Irish paediatric healthcare system or concerned about its future direction.

### Common Misconceptions About the CHI and the Irish Paediatric Healthcare Crisis

Misconception: *"This is just about a few isolated incidents."*

Reality: Investigations revealed systematic governance failures affecting hundreds of children.

Misconception: *"The problems are primarily about resource constraints."*

Reality: While funding is important, governance and cultural issues were primary factors.

Misconception: *"Moving to the new hospital will solve these problems."*

Reality: Without fundamental reform, the same issues will likely persist in the new facility.

Misconception: *"These issues only affected a small subset of vulnerable patients."*

Reality: The governance failures identified have implications for all children in the CHI system.

Beyond these specific questions lies a broader issue: how could a system specifically designed to protect vulnerable children fail so comprehensively in its mission?

The answers involve complex interactions between institutional culture, professional incentives, political priorities, and governance structures - with lessons that extend far beyond healthcare into how we design and oversee all public services.

What exactly happened with the “orphaned” children at CHI?

The “orphaned” children at CHI refers to a group of vulnerable patients who received substandard care long after national policy and clinical best practice dictated they should have been moved to more appropriate facilities.

Born before 2008, these children remained under the care of one CHI hospital despite another CHI facility being recognised as the centre of excellence for their particular conditions. Internal reports indicated these children were receiving suboptimal care with no clear governance pathway for their treatment, essentially falling into an administrative gap where proper treatment protocols weren't followed.

The situation persisted for years because of a toxic combination of territorial disputes between departments, inadequate transfer protocols, and a failure of leadership to prioritise patient welfare over organisational convenience.

When medical professionals raised concerns about these children's care, they often faced institutional resistance rather than support for addressing what were clear clinical governance failures. The term “orphaned” itself – though never officially used in documents – reflected how these vulnerable patients had effectively been abandoned by the systems designed to protect them.

The full extent of harm caused to these children remains unclear, as comprehensive reviews of their outcomes have only recently been initiated. However, preliminary findings suggest many experienced preventable deterioration in their conditions, underwent unnecessary procedures, or missed critical developmental windows for effective intervention.

These cases represent not isolated incidents but symptoms of systematic governance failures that potentially affected many more children throughout the CHI system.

How were waiting lists manipulated?

The manipulation of waiting lists for financial gain involved sophisticated techniques that exploited weaknesses in CHI's governance and information systems.

In some cases, consultants maintained artificially long public waiting lists while simultaneously seeing patients privately – sometimes in the same facilities using public resources. This created a situation where desperate families would eventually pay for private treatment from the very consultants responsible for the public waiting lists their children languished on.

More subtle forms of manipulation included selectively prioritising less complex cases that could be processed quickly to meet numerical targets while more difficult cases (which required more time and resources) remained untreated.

Some consultants also developed patterns of partial treatment – addressing minor aspects of a child's condition while leaving more complex issues unresolved, necessitating repeated visits that generated additional revenue in private practice.

The administrative categories used to classify waiting times were sometimes changed to make delays appear less severe than they actually were, illustrating the issue of lies, damned lies, and statistics.

What made these practices particularly difficult to detect was that they often occurred within technically permissible boundaries while violating the principles of public healthcare. The governance systems that should have identified these patterns lacked either the analytical capabilities or the independence necessary to recognise and address them.

When concerns were raised by administrative staff or other clinicians, they were often dismissed as misunderstandings or interdepartmental rivalries rather than investigated as

potential ethical breaches.

When will the New Children's Hospital finally open?

Current projections suggest the New Children's Hospital will open to patients in 2026, however others suggest it could be 2027 before children are treated there. Regardless, there has been a decade's delay from the original timeline.

Construction continues to face challenges and the operational planning for the transition is still in preliminary stages. The hospital will likely open in phases rather than all at once, with certain departments transferring before others to manage the complex logistics of the move.

The transitional plan faces significant challenges beyond construction timelines. CHI must develop comprehensive protocols for transferring patients, integrating clinical services, and establishing new operational procedures – all while maintaining continuity of care.

Given the governance issues identified in current operations, there are serious concerns about CHI's capacity to manage this complex transition effectively. Independent oversight of the transition process will be essential to ensure patient safety during this critical period.

Perhaps the most significant risk to the opening timeline is the current crisis itself.

If fundamental governance reforms are required before CHI takes responsibility for the new facility – as many healthcare experts are now suggesting – this could potentially delay the opening further. The alternative – transferring existing dysfunctional systems to a new building without addressing underlying problems – would represent an enormous missed opportunity and potential safety risk for patients.

Has anyone been held accountable for these failures?

To date, accountability for CHI's systematic failures has been limited and inconsistent. While some administrative leadership changes have occurred, these have often been presented as routine transitions rather than direct responses to identified failings.

Certain clinical practices have been suspended pending investigation, but comprehensive accountability that addresses both individual and systemic responsibilities remains elusive. This lack of clear consequences has contributed to public skepticism about whether meaningful change will actually occur.

The accountability gap extends beyond CHI to the broader oversight systems that failed to detect and address problems earlier. Regulatory bodies, political leadership, and HSE governance all share responsibility for allowing conditions to deteriorate to crisis levels before intervening.

Yet these broader accountability questions have received even less attention than those within CHI itself, creating a risk that the same oversight failures could recur in other Irish healthcare contexts.

What many families and healthcare professionals are now calling for is a comprehensive, independent inquiry with powers to establish both individual and systemic accountability.

Such an inquiry would need to examine not just what went wrong but why warning signs were ignored, how governance systems failed, and what changes are necessary to prevent similar failures in the future. Without this level of accountability, restoring public trust in Irish paediatric healthcare will be extremely difficult.

## **IS YOUR ORGANISATION AT RISK OF CATASTROPHIC FAILURE?**

The CHI crisis and its place in the broader Irish healthcare context contains crucial lessons for leaders in all sectors, not just healthcare.

The governance failures, cultural toxicity, and ethical breaches that undermined children's care represent organisational problems that can develop in any institution where accountability becomes diffused, transparency is compromised, and raising concerns is discouraged.

Recognising the early warning signs of these broken systems is essential for preventing similar crises in any organisation.

In the same way that strong leadership and clear governance structures are required in healthcare, every CEO, business owner, and leader needs the skills and mindset for continuous review and improvement to identify issues early and spearhead effective change.

*What are your thoughts and opinions on the crisis facing CHI and Irish healthcare? Let me know in the comments section below, and sign up to my mailing list so you never miss a post.*