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29 April 2019

Deputy Stephen S. Donnelly
Dáil Eireann
Leinster House
Kildare Street
Dublin 2

Re: PQs 17541/19 17542/19 and 17812/19

17541/19 To ask the Minister for Health if he will publish a UK review of orthodontic services here carried out between 2012 and 2015; and if he will make a statement on the matter.

17542/19 To ask the Minister for Health the timeline for the publication of an audit of orthodontic services begun in 2015 after the HSE received a highly critical report from two UK experts into the allegations that children's teeth were damaged by HSE orthodontic services more than a decade previously; and if he will make a statement on the matter

17812/19 To ask the Minister for Health when the Health Service Executive will publish its review into failings in dental and orthodontic services; and if he will make a statement on the matter.

Dear Deputy Donnelly,

I refer to the above Parliamentary Questions which have been referred by the Minister for Health to the Health Service Executive for direct response.

In 2015 the HSE received a Review Report that it had commissioned, following receipt of a 'statement of concern' from a Consultant Orthodontist in relation to an orthodontic service serving the Greater Dublin Area between 1999 and 2002.

The 'statement of concern' was initiated by the consultant who claimed that some children suffered damage as a result of interrupted orthodontic treatment at the time of a dispute between Consultant Orthodontists and the Health Boards (prior to the establishment of the HSE) in relation to the model of care for delivery of orthodontic services.

This original Review Report, of 2015, was in effect, a scoping report commissioned to advise the HSE on what actions should be taken to determine if there was a risk of harm to patients during the period.

The Report did not include examination of patients or a review of any patient records for the period and so, understandably, reliable conclusions could not be drawn at the time with respect to definitive patient harm.

Since receipt of the 2015 Report the HSE has initiated a comprehensive audit of over 7,500 patient files available from that period. Dedicated funding and personnel have been allocated by the HSE for this work.

Charts with an interruption of care noted are currently being reviewed by a clinician.

Due to the scale of the audit on the files and the requirements for dedicated personnel and resources the timeline has been protracted; however this work is now nearing its completion.

While it is regrettable that this work has taken a long time to progress, the priority of the HSE at all times has been for a robust audit on which to base any further action required.

The HSE has informed the Minister for Health that it cannot, as a matter of course, commit to the publication or otherwise of the Report prior to the completion of the audit process. The benefits of publication must be balanced with the requirement for patient confidentiality, and its obligation to afford natural justice to all other parties concerned.

Once the audit of patient files from the period is complete a HSE Serious Incident Management Team will consider the results to determine if a recall of any patient is required, and to coordinate open disclosure as necessary. The HSE expects to be in a position to make this determination in the next month and will then contact patients where necessary.

I trust this information is of assistance to you, but if you require further clarification please do not hesitate to contact me.

Yours Sincerely,

Joseph Green
AND, National Oral Health Lead - Operations