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01/04/2019

Deputy Róisín Shortall,
Dáil Eireann,
Leinster House,
Kildare Street,
Dublin 2.

PQ 10861/19
To ask the Minister for Health if a review (details supplied) has taken place; the plans of the HSE to publish the review; if so, when same will be published; and if he will make a statement on the matter.

-Róisín Shortall

Details Supplied: a review of cases related to the statement of concern that children had been damaged by the HSE Orthodontic Services in Dublin Mid-Leinster has been carried out at the request of the HSE by UK based Professors Stephen Richmond and David Bearn; if he will further confirm that this review was submitted to the HSE by Professors Richmond and Bearn on 6th February 2015

Dear Deputy Shortall,

The Health Service Executive (HSE) has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for response.

In 2015 the HSE received a review report that it had commissioned, following receipt of a statement of concern in relation to an orthodontic service serving the Greater Dublin Area between 1999 and 2002.

This original review 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 in this case.

The HSE cannot as a matter of course commit to the publication or otherwise of such reports prior to their completion, as the benefits of publication must be balanced with the requirement for patient confidentiality, and our obligation to afford natural justice to all other parties concerned.

The original review report, of 2015, did not include a review of any patient records for the period and so, understandably, reliable conclusions could not be drawn at the time with respect to potential 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. Due to the scale of the audit and the requirements for specialist staff and resources the timeline has been protracted, however this is work is now nearing its completion. While it is regrettable that this work has taken so long to progress, the priority of the HSE at all times has been for a robust audit on which to base any further action required.

When the audit of patient files from the period is complete a 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.

I trust this information is of assistance to you.

Yours sincerely,

David Walsh,
National Director Community Operations