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29th April 2021

Deputy Cullinane
Dáil Éireann,
Leinster House
Dublin 2

PQ Ref 18846/21 To ask the Minister for Health the process established under the HSE to ensure that recommendations of a report (IOG report) published in 2011 are implemented; the level of oversight that exists in the event that a clinician and or hospital fails to implement recommendations; and if he will make a statement on the matter.

Dear Deputy Cullinane

The Health Service Executive has been requested to reply directly to you in the context of the above Parliamentary Question, which you submitted to the Minister for Health for response. I have examined the matter and the following outlines the position.

Further to my response dated 30th March 2021 regarding PQ's 16496/21, 16497/21 and 16495/21, uterine rupture is a recognised event that can lead to serious injury to both the baby and the mother. An important cause of this event is rupture of a previous caesarean scar on the uterus. Uterine rupture is recorded as an event in the IMIS and the MSS. We also include it in the Obstetric Case Review Tool – Appendix A of the Neonatal Hypothermia Report (https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/annualreports/Published2019AnnualReport.pdf).

Several years ago we addressed this issue with the hospital groups in order to raise their awareness. The groups that we engaged with felt that they had addressed this issue sufficiently and at that time they felt it unnecessary to produce a national standard. It may be appropriate that we would raise this with our newly formed Maternity & Gynaecology CAG in the near future.

As long as women attend vaginal birth after caesarean section the risk of rupture remains, although it can be reduced to a very small level.

I trust this clarifies the matter.

Yours sincerely,

Mary-Jo Biggs, General Manager, National Women and Infants Health Programme

National Women & Infants Health Programme