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22nd December 2021

Deputy Bacik,
Dáil Éireann,
Leinster House
Dublin 2

PQ60120/21: To ask the Minister for Health the strategies he plans to put in place to implement the World Health Organisation recommendation that all countries assess the burden of stillbirths and neonatal deaths at a national level; and if he will make a statement on the matter.

Dear Deputy Bacik,

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

The national efforts described in our previous response to your Parliamentary Question 52032/21 align with the recommendations of the World Health Organisation; identifying cases, gathering information and analysing the data to improve the quality of care and to implement changes within a continuous evaluation and response cycle. I have reattached the response below for your convenience.

One of the key functions of The National Women and Infants Health Programme (NWIHP) is to provide oversight for the quality and safety of our maternity services. The ambition of NWIHP in this regard is to reduce the incidence of adverse events, enhancing the safety of maternity care. Data collection and analysis is vital in the quality improvement process. Recognising this, NWIHP have encouraged the development and implementation of the maternity focused Serious Incident Management Forum (SIMF) within each Maternity Network as a key objective of the Programme. These SIMFs provide robust and high level oversight of adverse outcomes within each Network and underpin the quality & safety standards in the 19 maternity units.

In addition, the NWIHP have established the Obstetric Event Support Team (OEST) to assist in extracting learnings from adverse events, providing a mechanism for sharing this learning locally and nationally. The OEST have identified early neonatal death as one event that requires particular attention. Valuable data that can influence clinical practice in a constructive way is also reported to NWIHP via Maternity Safety Statements (MSS) and the Irish Maternity Indicator system (IMIS). Annual IMIS reports can be found on the HSE website:

The NWIHP work collaboratively with the National Perinatal Epidemiology Centre (NPEC) to support the functions of the department and help to close the audit loop. The NWIHP has demonstrated continued commitment to the collection of NPEC's audit data, report publication and the implementation of its recommendations. NWIHP welcomes the recommendations of the recent NPEC report on Perinatal Mortality in Ireland and looks forward to working closely both with NPEC and the Institute of Obstetricians and Gynaecologists to review stillbirth and neonatal deaths to identify causal factors and mitigate risk where possible.

I trust this clarifies the matter.

Yours sincerely,



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