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02nd May 2023

Deputy Cairns
Dáil Éireann,
Leinster House
Dublin 2

PQ Ref 17220/23: To ask the Minister for Health to outline the steps he has taken to alter policy and practices in response to decisions by the Coroner's Court relating to infant deaths whereby the HSE and/or publicly-funded hospitals were found to be partially or wholly responsible for the deaths; and if he will make a statement on the matter

Dear Deputy Cairns,

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.

Continuous improvements in the quality and safety of services is a key focus for the HSE. Therefore when decisions and recommendations are made by the Coroner's Court in relation the death of an infant these are considered and reviewed in the first instance by the maternity service involved in the care of the woman. Where appropriate and applicable, learnings identified are shared at both regional and national level.

In additions to recommendations that come from the coroner's court, the HSE's Incident Management Framework 2018 (IMF) has put in place a person-centred response to the management of these adverse events. Incident review involves a structured analysis and is conducted using best practice methods, to determine what happened, how it happened, why it happened, and whether there are learning points for the service, wider organisation, or nationally. This is applied in all adverse events, including perinatal deaths.

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, including stillbirths and neonatal deaths, enhancing the safety of maternity care. Data collection and analysis is vital in the quality improvement process in addition to the

consideration and response to recommendations that can be made regarding safety and quality of the service.

Recognising this, NWIHP have supported 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 via Maternity Safety Statements (MSS) and the Irish Maternity Indicator system (IMIS). Annual IMIS reports can be found on the HSE website:

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-reports-on-womens-health/

The NWIHP work collaboratively with the National Perinatal Epidemiology Centre (NPEC) to support NPEC's annual reports on perinatal mortality, to ensure any recommendations are implemented.

The NWIHP have a programme for the revision and update of the National Clinical Guidelines for Maternity and Gynaecology services. The first tranche of 12 national clinical guidelines under this work programme were launched earlier in this year, with further suite of guidelines due to be launched at regular periods over the next one to two years. Guideline review will include consideration of both national and international best practices in the relevant clinical care areas, including those developed by NICE.

The review of these national clinical practice guidelines will be completed jointly by the HSE and the Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland. These guidelines are important to improving the quality and consistency of service delivery.

I trust this clarifies the matter.

Yours sincerely,

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

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á Forba

National
Women & Infants
Health Programme