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5th October 2023

Deputy O'Rourke
Dáil Éireann,
Leinster House
Dublin 2

PQ Ref 42187: To ask the Minister for Health to provide an update on the HSE's obstetric event support team within the National Women and Infant Health Programme; and if he will make a statement on the matter.

PQ Ref 42186: To ask the Minister for Health the protocol in place for the investigation of adverse incidents in labour; the criteria which determine whether a concise or comprehensive incident review is carried out; if it is the case that a comprehensive review is carried out in all cases of maternal death but not in the case of the death of a baby; and if he will make a statement on the matter.

Dear Deputy O'Rourke,

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

The Obstetric Event Support Team (OEST) is an initiative proposed by the National Women & Infants Health programme (NWIHP) as part of its quality and safety agenda. The membership of the OEST is made up of Obstetrician, Midwifery and Quality Patient Safety. The OEST is a service provided by the NWIHP to maternity hospitals/units to support the review process of a defined list of obstetric adverse events and provide a process for the sharing and implementation of learning and recommendations both locally and nationally.

The Obstetric Event Support Team OEST has designated three events that are within their remit, these are:
a) Intrapartum fetal death
b) Early neonatal death
c) Babies requiring therapeutic hypothermia

The OEST was implemented over two phases. To date the OEST have engaged on 50 cases, and have been informed of more in which meetings are outstanding. Phase one, from August 2021 involved the South South West, Limerick and Saolta Hospital Groups. Phase two commenced in April 2022 with engagement with Dublin Midlands Hospital Groups and Ireland East commencing in February 2023.

The HSE's Incident Management Framework (IMF), originally launched in 2018 was co-designed in collaboration with representatives from all levels in the service delivery system. Central to this process, was the level of consultation and collaboration with staff and patient groups that occurred throughout its development. The development process used assisted greatly in ensuring that the IMF provided services with a practical approach to the management of incidents which was aligned to best international practice. The IMF set out detail of the key principles and elements of a responsive and proportionate approach to the management of an incident i.e. from the prevention of incidents to learning from incidents which have occurred.

With regards to investigating adverse incidents in labour, the line manager in whose service the incident occurred will review the National Incident Reporting Form (NIRF) submitted to them, having identified the level of harm relating to the outcome of the incident. The level of harm experienced informs the categorisation of the incident. All maternal deaths are subject to comprehensive external review.

Incidents are categorised as follows:
1. Category 1 Major/Extreme – Clinical and non-clinical Incidents rated as major or extreme as per the HSE's Risk Impact Table.
2. Category 2 Moderate – Clinical and non-clinical incidents rated as moderate as per the HSE's Risk Impact Table.
3. Category 3 Minor/Negligible – Clinical and non-clinical incidents rated as Minor or Negligible as per the HSE's Risk Impact Table.

The criteria which determine whether a concise or comprehensive incident review is carried out relates to the level of harm incurred. Category 1 and Category 2 incidents require preliminary assessment to support a formal decision being taken in relation to review. Detail of the assessment and decision making process must be recorded using the Preliminary Assessment Form.

Category 1 incidents must be referred to the hospital or hospital group Serious Incident Management Team (SIMT) for decision making in relation to their management. Ideally, decisions relating to the review of Category 1 incidents should be made within 72 hours of occurrence of the incident and at latest must be made within one working week.

In order to assist decision making at the SIMT the Senior Accountable Officer (SAO), on notification of the incident, should assign an appropriate person, for example, the QPS Manager, to gather the information required for the completion of Part A of the Preliminary Assessment Form. This will be presented at the SIMT meeting in order to assist in framing the discussion relating to the need for further review of the incident.

Whilst all incidents must be subject to review, the level of review should be guided by the categorisation outlined above i.e.
Level 1 Review – Comprehensive Review (Category 1 incidents)
Level 2 Review – Concise Review (Category 2 and some Category 1 incidents)
Level 3 Review – Aggregate Review (Category 3 incidents)

I trust this clarifies the matter.

Yours sincerely,

MaryJo Biggs, General Manager, National Women and Infants Health Programme

National Women & Infants Health Programme