Saolta
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University Health Care Group

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Deputy David Cullinane
Houses of the Oireachtas
Kildare St
Dublin 2.

10th June 2025

PQ Number: 26923/25

PQ Question: *'To ask the Minister for Health the status of each ongoing investigation regarding patient safety incidents at Portiuncula Hospital; the department or service division to which the investigation relates; the person(s) responsible; the subject of the investigation; the commencement date of the investigation; the completion date of the investigation; and the current status of the investigation, in tabular form'*

Dear Deputy Cullinane,

The Health Service Executive has been requested to reply directly to you in the context of the above PQ submitted to the Minister for Health.

Portiuncula University Hospital (PUH) operates in line with the National Incident Management Framework. Point of entry reporting of patient safety incidents onto the National Incident Management System (NIMS) is in place in PUH. All incidents are managed under the local site incident management process and in line with the HSE Incident Management Framework. Action plans are put in place to address incidents at local level or a preliminary assessment review (PAR) may be undertaken to ascertain further information relating to the circumstances of the incident and follow up actions taken. A small number of incidents that are reported, including serious reportable events (SREs), are escalated to the regional Serious Incident Management Team for regional review and decision-making.

The SIMT is a multidisciplinary group of senior managers, clinicians, nursing and Quality and Patient Safety personnel that meets on a monthly basis to manage and monitor serious incidents from all hospitals in the West and North West RHA. SIMT is chaired by the Clinical Director of Quality and Patient Safety. SIMT considers PARs on new serious incidents or SREs arising across the region to decide on the ongoing management - closure following completion of the PAR, pursue through the complaints management process, chart review, other type of review as described in the Incident Management Framework (2020) or to conduct a full systems analysis based serious incident review.

In addition to the maternity incidents, one further incident, relating to another directorate, was escalated from PUH to the regional SIMT in 2025. This incident was discussed and closed at the 2025 January SIMT.

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The Hospital Patient Safety Indicator Report (HPSIR) is a monthly report that collates a range of patient safety indicators based on clinical activity, clinical incidents and clinical outcomes. This monthly report is published on the HSE website. Indicators published in this report are monitored by senior management of both the hospital and RHA on a monthly basis, as a key component of clinical governance.

I trust that this clarifies the position.

Yours sincerely,

Mr James Keane
General Manager