Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

Mr Cathal Crowe TD
Fianna Fáil
Dáil Éireann
Leinster House
Kildare Street, Dublin 2

23rd September, 2025

Re: PQ 44591/25

Dear Deputy Crowe,

Thank you for your question:

To ask the Minister for Health the details of responsibility for overseeing system analysis reviews to ensure they are done effectively, efficiently and within the timeline given to families; and if she will make a statement on the matter.

I refer to your parliamentary question above, which has been referred to HSE Quality and Patient Safety Incident Management for response.

The HSE Incident Management Framework 2020 [the Framework hereafter] sets out the process for the identification and management of patient (and staff) safety incidents within the HSE. The Framework aims to provide an overarching practical approach, based on best practice, to assist providers of HSE and HSE-funded services to manage all incidents in a manner that is cognisant of the needs of those affected and supports services to learn and improve.

The Framework describes that the timeframe for concise and comprehensive reviews should not exceed 125 days from the time of the incident. It is however, accepted that in some circumstances this timeframe will not be achievable, for example when a Review Team is commissioned external to the area where the incident occurred (page 25, HSE Incident Management Framework, 2020).

In line with the HSE's Performance and Accountability Framework 2025 the Senior Accountable Officer (the individual with ultimate accountability and responsibility for the service within which the incident occurred) is required to have formal performance management arrangements in place with the individual services they are responsible for, to ensure delivery against performance expectations and targets.

Once an incident has been reported it is categorised on the basis of the level of harm which has occurred as a result of the incident. The purpose of categorising incidents is to assist with determining the level of review required. There are three levels of review set out in the

Framework. Within each of these levels a number of approaches to review have been endorsed for use within the HSE and HSE funded services.

Responsibility for commissioning of a review is dependent on the category of the incident. On this basis reviews may be commissioned by the Senior Accountable Officer or the Local Accountable Officer (local manager) in whose area of responsibility the incident occurred. The review commissioner is responsible for ensuring that there are clear governance arrangements in place to support the conduct of the review. This includes the establishment of the review, oversight during its conduct, receipt of the final report including a governance approval process for the acceptance of final review reports and the development and monitoring of action plans required to implement any recommendations made as a consequence of the review.

In addition, the Framework sets out additional specific governance arrangements that are required to support the management of those incidents that have the most serious outcomes (Category 1 incidents).These incidents are managed through a Serious Incident Management Team (SIMT) which is chaired by the Senior Accountable Officer and includes nominated members of the relevant executive management team.

The role of the SIMT includes making decisions about the commissioning of a review in the case of a Category 1 incident, monitoring the management plan and timeframes for the management of an incident including any review commissioned in respect of the incident and taking and recommending action where timeframes are at risk.

The SIMT also has a role in the quality assurance and approval of final draft review reports to ensure that these have been completed in line with their terms of reference and have achieved their objectives with regard to the identification of any learning arising out of an incident.

The Framework can be accessed in full here.

Yours sincerely

Lorraine Schwanberg
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Quality and Patient Safety Incident Management, Open Disclosure and NIMS