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23/05/2024

Deputy Shortall,
Dáil Éireann,
Leinster House
Dublin 2

PQ 21806/24: To ask the Minister for Health the person or body responsible for the oversight and accuracy of deaths reported in the HSE monthly maternity patient statements; if all maternity hospitals are recording baby deaths; if not, the repercussions for not doing so; if discrepancies between CSO and HSE data in respect of baby deaths has been reviewed; if so, the reason these sets of data do not correlate; and if he will make a statement on the matter.

Dear Deputy Shortall,

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 on the various areas and issues you raised.

Maternity Safety Statements are published for each of the country's 19 maternity hospitals and units. Each Hospital Group and Maternity Hospital publish an updated statement each month.

The objective of publishing these statements is to provide public assurance that maternity services are delivered in an environment that promotes open disclosure. It is intended that reporting in an honest and open way helps build trust and improves clinical performance and the culture of safety. The Maternity Safety Statement contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents. While all maternity hospitals collect a large range of information and data on an ongoing basis, these particular metrics have been selected on the basis that they are clinically robust, relevant and underpinned by standardised definitions.

The statements also inform hospital management in carrying out their role in safety and quality improvement. It is intended that they act as an early warning mechanism for issues that require local action or any issues that need intervention at Hospital Group or national level. Like all performance measurements, the data should be interpreted with caution particularly when reporting low numbers which may vary naturally from month to month and are influenced by case complexity.

It is not intended that the monthly Maternity Safety Statements be used as a comparator with other units or that they would be aggregated at Hospital Group or national level. It is important to note tertiary and referral maternity centres will care for a higher complexity of mothers and babies. Rates of clinical activity, and outcomes, will be higher and therefore these should not be compared with units that do not look after such referred complex cases.

Maternity Safety Statements are discussed at the periodic engagement meetings between The National Women and Infants Health Programme (NWIHP) and the Hospital Group Maternity Networks. This engagement is seen as key to promote connectively between NWIHP and the 19 maternity hospitals/units and promotes a culture of quality and safety.

The Statement is set out under a number of headings as follows:

Hospital Activities - information is reported on the number of women delivering babies for the first time, the number who have previously given birth, the number of multiple pregnancies, perinatal mortality rates and transfers in and out to hospitals.

Major Obstetric Events – information is provided on a range of rare but potentially life-threatening events that could occur within maternity services. These include eclampsia, uterine rupture, peripartum hysterectomy and pulmonary embolism. As the numbers for these rare events are small, they will be reported and published as a combined rate per 1,000 mothers delivered.

Modes of Delivery: information is provided on the rate of delivery of babies through induction of labour, instrumental delivery or caesarean section.

Total Number of Clinical Incidents for maternity services reported in the month: This information relates to the total number of incidents recorded on the National Incident Management System. This system has been rolled out as a joint initiative with the State Claims Agency.

Also included in the Statements are the Rate of perinatal deaths (i.e., including stillbirths and early neonatal deaths (from delivery to 6 completed days)) weighing ≥2.5kg without a congenital anomaly (i.e. without physiological or structural abnormalities that develop at or before birth and are present at the time of birth). Rate is calculated per 1,000 total births.

With regards to the discrepancies between CSO and HSE data in respect of baby deaths, there is a delay in reporting to the CSO through the Coronial process and unfortunately this can cause a delay as stated on the CSO website when an inquest takes place*: "Births and deaths (where no inquest has been held) which have not been registered within one year of their occurrence can be registered only on the authority of the Superintendent Registrars. The tables in the main body of this report exclude such births and deaths. The Appendix to the report contains an analysis of late death registrations in 2020 and of some deaths where an inquest has been held."*

I trust this clarifies the matter.

Yours sincerely,

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