DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE AGUS LEANAÍ

JOINT COMMITTEE ON HEALTH AND CHILDREN

Dé Máirt, 19 Bealtaine 2015

Tuesday, 19 May 2015

The Joint Committee met at 11.30 a.m.

MEMBERS PRESENT:

Deputy Catherine Byrne,	Senator Colm Burke,
Deputy Ciara Conway,	Senator John Crown,
Deputy Regina Doherty,	Senator John Gilroy.
Deputy Robert Dowds,	
Deputy Peter Fitzpatrick,	
Deputy Seamus Healy,	
Deputy Billy Kelleher,	
Deputy Mary Mitchell O'Connor,	
Deputy Dan Neville,	
Deputy Caoimhghín Ó Caoláin,	

In attendance: Deputies Lucinda Creighton and Sean Fleming.

DEPUTY JERRY BUTTIMER IN THE CHAIR.

The joint committee met in private session until 11.42 a.m.

HIQA Investigation into Midland Regional Hospital, Portlaoise (Resumed): Parents and Patient Advocates

Chairman: I remind members, witnesses and those in the Public Gallery to turn their mobile phones off as they interfere with the broadcasting of our proceedings. Apologies have been received from Senators Henry, van Turnhout and Crown. Today's meeting was arranged at short notice to follow up on our meeting with HIQA regarding its report on patient safety and maternity services in Portlaoise and our quarterly meeting last Thursday with the HSE. Given the serious findings arising from the report and previous delays in its publication, I advise members to exercise caution, if they can, in referring to the issues without naming specific individuals. On Wednesday, the committee had a very thorough and strong meeting with HIQA, which presented a summary of the findings of its inquiry into safety, quality and standards of services provided by the HSE to patients in the Midland Regional Hospital, Portlaoise. The main purpose of today's meeting is to listen to a number of very important people, the families, parents and patient advocates. I extend a warm welcome to Mr. Ollie Kelly, Ms Amy Delahunt, Mr. Mark Molloy, Ms Róisín Molloy, Ms Sheila O'Connor and Ms Cathriona Molloy. I thank them for coming here at such short notice. I also thank them for their courage in speaking out and being very strong advocates for us as citizens.

Our second session this afternoon will give us the opportunity to discuss the HIQA report in greater detail with officials from the HSE. All members of the committee have been very focused on the report and our primary focus is on the families and parents who have experienced such sad tragedy and bereavement in Portlaoise hospital. I have stated on the record previously, and I do so again this morning, that there is cross-party support for their tenacity and courage not just in the aftermath of this report being published but beforehand also. We all know that the story of childbirth should be a time of joy but in this case, and in many cases, it was one of loss. We need to allow the parents in this case to have an opportunity to speak to a committee in Oireachtas Éireann, the people's House.

I thank our witnesses for being here today. Our focus will be on the stories that will be told. We will hear first from Sheila O'Connor, national co-ordinator of Patient Focus, which advocated on behalf of many families in the Portlaoise hospital inquiry. We will then hear from the different people involved.

Before we begin, it is important for us as a committee to acknowledge the loss of baby Mark and baby Mary Kate, and the tragic loss of other babies also, whose memory is foremost in our thoughts.

I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the long-standing parliamentary practice and ruling of the Chair to the effect that they should not

comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

As is the custom, I will begin by hearing from committee members after the opening presentations, and then move to non-committee members. I call Ms Sheila O'Connor to make her opening remarks.

Ms Sheila O'Connor: Patient Focus would like to begin by thanking the Chairman, Deputy Jerry Buttimer, and other members of the Oireachtas Joint Committee on Health and Children for their invitation to speak on this important occasion of the publication of the Health Information and Quality Authority, HIQA, report. I would also like to thank the clerk to the committee and his staff for their invaluable help in putting this together at such short notice.

I would like to tell the members about Patient Focus and patient advocacy. Most importantly, I will explain a little about our involvement in the Portlaoise scandal. I would also like to tell them about the beginnings of Patient Focus and what we have achieved through advocacy to date. I have provided a backup document, Problems Patients Experience, concerning the most common problems experienced by people who contact us and how we endeavour to help them through advocacy.

Patient Focus is an Irish national patient advocacy service. We were set up in 1999 and established as a company limited by guarantee shortly afterwards. We have charitable status. We have four staff and are funded by the Health Service Executive, HSE, at the rate of €216,000 per annum.

Why is patient advocacy necessary and what is it? Too many people are injured physically, emotionally and psychologically by health care. That is not widely known or understood. We listen to patients' stories which, sadly, are often chaotic. By listening to them we help them make sense of it. Their journey with us can be as short or as long as they want; it is entirely up to them.

Advocacy can mean something as exceptional and unusual as arranging last week's meeting of the affected families in Portlaoise. More usually, it means providing assistance with regard to obtaining records, attending meetings with appropriate professionals to discover what happened, explaining processes or accompanying patients to investigations and reviews. All of that involves familiarity with and access to people within the health care system. It also involves working with outside professionals such as counsellors, doctors, coroners and lawyers, depending on the seriousness of the matter. We sit on various reviews at local and national level for the HSE, the Nursing and Midwifery Board of Ireland and HIQA. We give regular briefings to the HSE on the issues that arise. We have constructive relationships with decision makers in the political and health care areas. In this we are unique nationally and internationally.

Our ethos is patient and person-centred. We understand it is very important to listen, to go at the patient's pace and to be led by them at all times regarding the decisions they make. This approach springs from the view that the individual person's dignity, autonomy and power of decision making is protected at all times.

Staff members of Patient Focus have been involved in patient advocacy since 1996. In a short space of time, in the mid to late 1990s, the extent of the damage suffered by some patients became very clear to us. Sometimes this damage and hurt lasts a lifetime. As we began to listen to many sad and disturbing stories, we resolved that the health care system needed to listen

too and to take notice of the damage people experience. It also applies to relatives. It is very important that people find their voice. In the late 1990s, it became clear that people were no longer willing to be written out of the history of the practice of medicine. Damaged patients felt they were placed in corners, forgotten about and treated as an embarrassment by the very people and institutions tasked with their care. In the late 1990s, it also became clear to us that patients' issues fell into a number of categories and the backup documents I have provided to the joint committee explain those categories. They also relate to all areas of the health service.

I will now talk a little about our involvement with the Portlaoise maternity unit and the people who have asked me to appear before the joint committee today, for which I have been very honoured and thank them. Our staff of four provided support to approximately 200 families affected by revelations about maternity care nationally but most particularly in respect of Midland Regional Hospital, Portlaoise. We met Mark and Róisín in 2012, when they told us the awful story of what happened to their baby. From early 2013, we worked with a small number of bereaved families and mothers to bring to the attention of the Health Service Executive, the Department of Health, the Health Information and Quality Authority and the public what appeared to be the unnecessary deaths of four healthy, full-term infants in Portlaoise. These babies were Mark, Joshua, Katelyn and Nathan. They died during labour or shortly after delivery as a result of oxygen deprivation. Then we heard of Amy and Ollie's little baby, Mary Kate. These parents will explain much better than I can, during the course of this meeting, how difficult the entire process has been for them.

Stories of damaged babies and injured mothers in Portlaoise, as well as concerns about safety in other maternity units, came flooding in to Patient Focus after the RTE "Prime Time" programme. Within days we had approximately 180 contacts from worried people, 80 of which were from Portlaoise. Other concerns came from units throughout the country including, but not exclusively, Mullingar, Cavan, Portiuncula, Tralee, Letterkenny, Wexford and Sligo. There also were serious complaints about care at the three major Dublin hospitals. No hospital escaped. Heartbreaking stories emerged, some from as far back as the 1970s and 1980s, some recent and others as recent as the previous weeks. What united them is they were all visceral in the grief expressed at the loss or damage to babies. I think any human being can understand that completely. Within days of the programme, the Department of Health set up a scoping review of the hospital and concluded that the maternity unit in Portlaoise was unsafe. This caused huge challenges, both personal and financial, for Patient Focus and its staff. Commitments made at the time in terms of increased funding to cover the cost of increased travel, staff work, etc. have not been honoured by the HSE.

A number of reviews have been established, including HIQA investigations and an internal HSE review into some 200 cases. In some cases, individual clinical reviews were also established as a result of the information that came flooding in. The results of most of these reviews, with the exception of the HIQA investigation, are still awaited. We believe these delays are completely unacceptable. The families present will tell members about the effects of such delays and the energy necessary to obtain a review in the first instance. In Patient Focus, we believe that when adverse events occur, an external review of care should be offered immediately by relevant experts. We believe matters should be explained openly and sympathetically to the people concerned within a month of the occurrence. In the interests of patient safety and learning, the HSE can continue to conduct its own reviews. It became clear to us last week that the first anniversary had been reached for a number of other babies who had died in similar circumstances and the parents still had no idea why their little baby died. Moreover, they are still waiting and probably will wait for a considerable time to find that out, which in my view

is completely inhumane.

How did Patient Focus develop and what are our achievements? Many changes have occurred since we began our work, much of it achieved by our clients, although many more changes are still required. Prior to the freedom of information legislation in 1997, Irish patients had no legal right of access to their own medical records. Indeed, such was the lack of interest in this legislation within the public health system at the time and even into the mid-2000s, it was very difficult for any but the most persistent patient even to obtain a copy of their medical records. Today there is still no legal right to medical notes from private hospitals or institutions, or for private patients of general practitioners. That is totally unacceptable.

In the late 1990s, there was no formal complaint system in operation and often the only way patients could receive answers to their questions was to consult a solicitor. In the late 1990s, members of Patient Focus spoke to staff in the system about the establishment of a patient complaint office. They told us of proposals to establish patient liaison offices but that the word "complaint" could not be used because of strong negative feedback from some staff. Some staff believed "patients do not have complaints" or worried it would just encourage complaints from cranks or disgruntled patients. The expression I have quoted is an exact one heard at the time. Indeed, a medical member of Patient Focus who advocated support for damaged patients at the time was described by some colleagues as a "turkey voting for Christmas". This is not really all that long ago. It was ten or 15 years ago.

At this time, the regulation of doctors was effectively in secret also, behind the closed and secure doors of Lynn House, the headquarters of the Medical Council at the time. Poor performance as a doctor was not medical misconduct so medical error, however serious, could not found a fitness-to-practise inquiry and result in the removal of a doctor from the medical register. However, I am thankful the Medical Practitioners Act of 2007 changed all this. It must be said that this was mainly as a result of patients who persisted despite the huge financial and other risks involved to them and their families. These patients were supported by numbers of doctors and nurses actively engaged in their professional work at the time. This has to be said because it is true. Notably, among these patients are a number associated with groups who came together with Patient Focus to claim their pain and hurt as real and to make sure the system heard them. These are the victims of Drs. Michael Neary, Paschal Carmody and Michael Shine. All three of these doctors have been removed from the medical register for serial professional misconduct of different types.

We supported 200 symphysiotomy patients and are very pleased with the response by our clients to the payment scheme. We currently support people who had the DePuy hip implants and faulty breast implants. There were others also, and it must be said that Patient Focus was building on the work of other groups at that time, for example, Positive Action and Parents for Justice. We also worked with the members of what were to become Dignity 4 Patients and the Irish Patients Association. I should have mentioned the staff of Children in Hospital Ireland. They provided invaluable emotional support and support in many other ways.

Let me outline the main area in which Patient Focus works. In addition to the above, Patient Focus supports approximately 450 patients and their families in obtaining answers to their concerns and complaints each year. This constitutes the vast bulk of our work and it is ongoing. Patients without group support are particularly vulnerable because they are on their own. Sometimes even their own families are unable to assist them. This is where advocacy is most important. The concerns of the group of 450 people arise in all areas of health care, including general practice; public, voluntary and private hospitals; nursing homes and the older people

sector; obstetrics and gynaecology; disability; nursing; the ambulance service; and children's services.

Historically in Patient Focus, if one can speak historically about such a young organisation, its role in regard to psychiatric patients was to assist them with concerns over their care in the physical health area. However, in 2014 we received an increasing number of requests relating to the mental health service *per se*. We help where possible, usually in relation to complaints, but our expertise in this is limited. In the past we did work with the Irish Advocacy Network, which we found very helpful and empathic. However, it does not seem to be funded currently. That is probably the reason for the huge increase.

With regard to the future of patient advocacy, Patient Focus welcomes the HIQA recommendation concerning a national advocacy service. We have been doing this work for almost 20 years with few resources but with some considerable success, of which we are very proud. We have the necessary skills to develop such a service and ask for the committee's active support to achieve this in the short term.

Chairman: Thank you, Ms O'Connor. I call Mr. Mark Molloy to make his opening statement.

Mr. Mark Molloy: On behalf of Róisín and I, the parents of Mark, as well as Amy and Ollie, the parents of Mary Kate, I thank the committee for the opportunity to address it. In particular, we want to express our gratitude to Deputies Lucinda Creighton and Billy Kelleher for their considerable time and effort outside this forum.

The following is a statement to the Oireachtas Joint Committee on Health and Children regarding perinatal deaths, maternal and infant injuries at the Midland Regional Hospital, Portlaoise and a chronology of documentation relating to wider patient safety concerns.

On the morning of 24 January 2012, our fifth son, Mark, passed away moments after delivery at the Midland Regional Hospital, Portlaoise. In the intervening three years and four months, Róisín and I have fought against continuous considerable opposition to get an answer to our initial simple question - what happened? How did our boy die? It is a question, we now know, following receipt of additional information under freedom of information in April 2014, to which the HSE had answers within days of Mark's death. Despite being informed by the hospital obstetric and midwifery management that the death of a healthy baby during labour was extremely rare, it became apparent to us very early on that we were not the only family whose healthy child had died in similar circumstances at the hands of this and other regional maternity units nationally.

Chairman: Can I stop Mr. Molloy for one second, please? If there is a mobile phone on, could the person please turn it off because it is interfering with Mr. Molloy's presentation. To be fair to him and the families, it is important they have their opportunity to speak without any outside interference. If there are mobile phones, they should be turned off. I will ask Mr. Molloy to start that paragraph again, please.

Mr. Mark Molloy: Yes. Despite being informed by the hospital obstetric and midwifery management that the death of a healthy baby during labour was extremely rare, it became apparent to us very early on that we were not the only family whose healthy child had died in similar circumstances at the hands of this and other regional maternity units nationally.

Consequently, a huge burden of responsibility became the overriding drive to get action and

intervention to save other families suffering the heartache and loss that we were enduring. The details of our children's deaths, injuries to others and the experiences of families in their dealings with the hospital and HSE have been relayed to HIQA and formed much of the basis of their report issued on 8 May 2015. Therefore, we aim to use this opportunity today to set out the extent and steps in which we engaged since January 2012 to bring our concerns regarding the safety of these maternity units to people who had a duty to act and intervene.

In the immediate aftermath of Mark's death, we made a complaint to hospital management at the Midland Regional Hospital, Portlaoise. At every juncture thereafter, as we encountered a lack of action and-or urgency, we continually moved up to more senior HSE management levels, first regionally and then nationally, conveying both our own story and those of others of which we had learned since Mark's death, as well as our fears for the safety of other patients attending the unit. We also sent correspondence and sought meetings with the Secretary General in the Department of Health. At every single stage, we firmly believed we were informing each new level of management encountered of serious patient safety issues of which they were totally unaware.

We later learned of the State Claims Agency's attempt at intervention in 2007, the O'Doherty and Fitzgerald report following the breast cancer scandal at the Midland Regional Hospital, Portlaoise in 2008, staff concerns raised on numerous occasions, the Avalon foetal monitor operational recall in 2009 and update in 2011, the completion of and recommendations from Nathan Molyneaux's investigation in August 2011, and the completion of and recommendations from Katelyn McCarthy and Joshua Keyes' investigations in November 2011. Despite this, our concerns continued to be ignored.

The reaction and intervention noted in the aftermath of the publicity surrounding the death of Savita Halappanavar were apparent. We eventually made the difficult decision after two years of rigidly sticking with the HSE's procedures that highlighting our concerns through media was the only option if any meaningful intervention and-or change were to occur. The following schedule sets out a record of the main correspondence we have on file in the period of February 2012 to April 2013 in relation to Mark's death and our serious concerns for the safety of mothers and babies attending the Midland Regional Hospital, Portlaoise. I will take the committee through the schedule. It is quite long but it paints a picture when one reads it from start to finish.

SCHEDULE OF CORRESPONDENCES IN RELATION TO MARK'S INVESTIGATION and WIDER PATIENT SAFETY CONCERNS

Date	Sent/Received	To/From	-
22 February 2012	Sent to	Manager - Midlands Regional Hospital Portlaolse and copied to National Director for Quality and Patient Safety	Letter of Complaint
28 February 2012	Minutes of Meeting	Governance - Midlands Regional Hospital Portlaoise	Baby Mark's Investigation

30 March 2012	Minutes of Meeting	HSE Risk Manager - Dublin Mid Leinster Region	Baby Mark's Investigation
1 July 2012	Sent to	Secretary General in Dept of Health	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
18 July 2012	Sent to	HSE Assistant National Director of Acute Services	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
15 August	Sent to	NPEC - National Perinatal Epidemiology Centre	Incorrect Stillbirth Classification and Concerns Regarding Maternity Services at MRHP
21 October 2012	Sent to	Secretary General, Department of Health	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
22 October 2012	Sent to	HSE Assistant National Director of Acute Services	Informing of Decision to Escalate to National Level
22 October 2012	Sent to	HSE National Director for Quality and Patient Safety	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP and Meeting Request
25 October 2012	HSE Internal email	HSE Risk Manager Dublin Mid Leinster Region to Co-Chairpersons NIMT	Update on Baby Mark's Investigation
26 October 2012	HSE Internal email	HSE National Director for Quality and Patient Safety to HSE Co-Chairpersons NIMT	Proposed Response to Family Regrading Concerns Raised
26 October 2012	HSE Internal email	HSE Co-Chairpersons NIMT to HSE National Director for Quality and Patient Safety	Discussions Regarding High Rates of Harm in Maternity and Other Services Nationally

26 October 2012	Received From	Secretary General, Department of Health	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
26 October 2012	Received From	HSE Director General	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
30 October 2012	Received From	HSE National Director for Quality and Patient Safety	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
21 November	Minutes of Meeting	Co-Chairpersons-NIMT	Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP
23 November	Sent to	National Director for Quality and Patient Safety HSE	Request for Meeting
25 November 2012	Sent to	HSE Director General	Baby Mark's Investigation Delays andConcerns Regarding Maternity Services at MRHP
30 November 2012	HSE Internal email	HSE Risk Manager - Dublin Mid Leinster Region to HSE National Director for Quality and Patient Safety cc HSE Co-Chairpersons NIMT and HSE Assistant National Director of Acute Services	Update on Baby Mark's Investigation Delays and Concerns Regarding Maternity Services at MRHP

On 22 February 2012, we sent a letter to the manager of the Midland Regional Hospital, Portlaoise and copied the national director for quality and patient safety. It was a letter of complaint concerning Mark's birth and death. The minutes of a meeting we had with the governance of the Midland Regional Hospital Portlaoise are dated 28 February 2012. The subject of the meeting was Mark's investigation. The minutes of a meeting dated 20 March 2012 are for a meeting with the HSE risk manager for the Dublin Mid-Leinster region the subject of which, again, was Mark's investigation. Correspondence dated 1 July 2012 was to the Sec-

retary General of the Department of Health, facilitated through Patient Focus and relating to delays in Mark's investigation and concerns on the maternity service at the Midland Regional Hospital, Portlaoise. On 18 July 2012, a letter was sent to HSE national assistant director for acute services on delays in Mark's investigation and concerns about services at Portlaoise. On 15 August 2012, a letter was sent to the National Perinatal Epidemiology Centre, or NPEC, on the incorrect classification of Mark as stillborn and concerns about the maternity services at Portlaoise.

On 21 October 2012, a letter was sent to the Secretary General of the Department of Health on delays in Mark's investigation and concerns about services in the maternity unit at Portlaoise. On 22 October 2012, a letter was sent to HSE assistant national director for acute services informing him of our decision to escalate to national level due to inaction. On 22 October 2012, a letter was sent to the national director for quality and patient safety on delays in Mark's investigation and concerns about services in the maternity unit at Portlaoise and requesting a meeting. Next is a HSE internal e-mail dated 25 October 2012 from the risk manager of the Dublin mid-Leinster region to the co-chairpersons of the national incident management team, or NIMT, regarding an update on Mark's investigation. Next is another HSE internal e-mail from the national director for quality and patient safety to the HSE co-persons of NIMT on proposed response to the family regarding the concerns raised. Next is another HSE internal e-mail from the co-chairs of NIMT to the national director for quality in patient safety discussing high rates of harm in maternity and other services nationally dated 26 October 2012. Also on 26 October 2012 is correspondence received from the Secretary General of the Department of Health on delays in Baby Mark's investigation and concerns about services in the maternity unit at Portlaoise. Also dated 26 October 2012 is correspondence received from the HSE director general on delays in Mark's investigation and concerns about services in the maternity unit at Portlaoise. On 30 October 2012 there is correspondence received from the national director for quality and patient safety on delays in baby Mark's investigation and concerns about services in the maternity unit at Portlaoise.

On 21 November 2012 are dated minutes of a meeting Róisín and I had with Sheila present with the co-chairs of the national incident management team on Mark's investigation and concerns about services in the maternity unit at Portlaoise. That was a three-hour meeting. On 23 November 2012 is dated correspondence sent to the national director for quality and patient safety requesting a meeting as we were very unhappy with the meeting of 21 November. Correspondence dated 25 November 2012 was sent to the HSE Secretary General on delays in Mark's investigation and concerns about services in the maternity unit at Portlaoise. On 30 November 2012 there was an internal HSE e-mail from the HSE risk manager for the Dublin mid-Leinster region to the national director for quality and patient safety copying the co-chairs of NIMT and the assistant national director for acute services concerning an update on Mark's investigation delays and discussions regarding concerns at Portlaoise.

Dated 2 December 2012 are minutes of a meeting between the HSE director for quality and patient safety with Róisín and I in the presence of Patient Focus on Mark's investigation and concerns about Portlaoise. This was a three-hour meeting, again, which took place on a Sunday just before Christmas in Dr. Steevens' Hospital. Dated 3 December 2012 is a HSE internal e-mail from the co-chairs of NIMT to the HSE national director for quality and patient safety and HSE risk management for the Dublin mid-Leinster region on key actions agreed from a teleconference. Dated 6 December 2012 is notice of a meeting with no minutes received. It is on our file as just notice of a meeting between the HSE director general and the national director for quality and patient safety and it may be that an agenda item was baby Mark Molloy's

investigation. Dated 8 December 2012 is a HSE internal e-mail from the national director for quality and patient safety to the HSE co-chairs of NIMT on concerns regarding the maternity services at Portlaoise. Correspondence dated 10 December 2012 was a mapping document to the HSE, Health Service Executive, advocacy team on non-clinical complaints against HSE response and actions in dealing with Mark's death. Essentially, while there was the clinical investigation going on in to Mark's death, we were also very unhappy with the way we had been treated to that point. We said people had misled us from day one which needed to be looked into. Accordingly, a separate investigation was launched by the HSE into that.

Correspondence on 13 December 2012 concerned a HSE internal e-mail from the HSE co-chairpersons NIMT, national incident management team, to the HSE national director for quality and patient safely on discussions regarding high rates of harm in maternity and other services nationally.

Correspondence was sent on 11 January 2013 to the HSE national director for quality and patient safety, amending omission from minutes of meeting of 2 December to include review of all perinatal deaths at Portlaoise.

On 13 January 2013, correspondence was received from the HSE national director for quality and patient safety confirming data from Portlaoise would be included as an action item for national director for quality and patient safety.

Correspondence on 15 January 2013 involved a HSE internal e-mail from the national director for quality and patient safety to the HSE co-chairpersons NIMT confirming data from MRHP, Midland Regional Hospital Portlaoise, should be reviewed.

On 13 February 2013, correspondence was sent to the HSE national director for quality and patient safety on baby Mark's investigation delays and the need to act on concerns regarding this unit.

Correspondence on 15 February 2013 comprised a HSE internal document from the HSE national advocacy unit to the HSE national director for quality and patient safety on clinical complaints to be investigated by NIMT to national director for quality and patient safety HSE. The advocacy team sent certain elements on to the director stating it was outside the scope of its investigation and should be handled by the director for quality and patient safety.

Correspondence on 13 March 2013 involved a HSE internal document from the HSE national director for quality and patient safety to the HSE national director for service user advocacy which was a response to above correspondence of 15 February 2013 stating he would take on that role.

Correspondence on 12 April 2013 comprised a HSE internal e-mail from the HSE national director for quality and patient safety to the HSE co-chairpersons NIMT, Department of Health and the HSE head of legal services for a request by the former Minister of State, John Moloney, on our behalf for a meeting with the Secretary General of the Department of Health regarding Mark's investigations and concerns for wider patient safety. The meeting did not happen.

The last correspondence was received in April 2014 regarding a HSE internal document prepared by the director of nursing at Portlaoise hospital on 30 January 2012. It was a desk-top review confirming the reasons Mark died, six days after he had died.

In October 2013, Mark's investigation report was finally completed. Following this, we re-

quested a meeting and met with the HSE national director for quality and patient safety and the HSE national director for patient advocacy to discuss the HSE's plan for the implementation of the 43 recommendations contained in Mark's report which had both local and national service implications. Despite all of the foregoing meetings and correspondences set out, the numerous other correspondences, phone calls and meetings, coupled with the completion and findings of the investigation, both said they were there to listen to our story. At that stage we made the decision to speak to RTE's investigations unit.

Following the "Prime Time" investigation unit's programme which aired on 31 January 2014, Patient Focus received in excess of 180 calls from concerned parents. We were contacted directly by Amy and Oliver whose daughter, Mary Kate, had passed away in May 2013 in similar circumstances. We were also contacted by Nicki and David Reddington whose daughter, Síofra, passed away in February 2013 and another couple whose son received a severe birth injury in November 2013. All of these birth outcomes were after the above highlighted correspondences and meetings.

The harrowing stories of the many people who spoke of so many deaths and life-changing injuries at the meeting with the Minister for Health, Deputy Varadkar, last Wednesday, 13 May, after years of uncanny accounts of being misled, ignored and silenced by the HSE, disclosed the extent of the depths of this scandal.

We conclude by stating we vehemently disagree that this scandal was the result of ignorance or a "lack of escalation". There appears to have been an attempt at both local and national level to suppress repeated known red flags, which perpetuated failings, leading to repeated deaths and injuries, at huge emotional, physical and financial cost to families and patients.

Ms Delahunt will put the following recommendations to the committee.

Ms Amy Delahunt: As the mother of Mary Kate who died in May 2013, with the other parents in question, I demand to know how her avoidable death and the deaths of others were allowed to happen. The HSE must stop misinforming the public that these issues were not escalated nationally. The director general of the HSE must stop misinforming the public that these events occurred before his time in the HSE. Following the assertions made in HIQA report that financial matters were prioritised over all other considerations within the HSE, can the committee establish why funds from the HSE's budget are continually used to employ legal teams and senior counsel to limit the scope of inquests and any derived learning and why patients were continually encouraged to go down the route of litigation, thus invoking section 48 of the Health Act which states any matter that is or has been the subject of litigation cannot be investigated by the HSE?

Given this presentation, the Minister must initiate an investigation into all levels of HSE management relating to this scandal. This HSE management team is clearly incapable and cannot be trusted to implement the recommendations made in this or previous HIQA reports.

Chairman: I thank Ms Delahunt, Mr. Molloy and Ms O'Connor for their presentations. Representatives of the HSE will appear before us this afternoon and have the right to reply. I will move to questions from members of the committee.

Deputy Billy Kelleher: I welcome our guests and thank them for their presentations. I wish to be associated with the Chairman's opening remarks on what they have experienced personally through their tragic losses at the Midland Regional Hospital, Portlaoise. HIQA

produced a report on maternity services and services more broadly at the hospital that makes for very difficult reading, even when one removes oneself from the emotional aspect, in terms of management and how the hospital was run and supported at regional and national level. It was said red flags were being raised and alarm bells were ringing, but it seems that they were continually ignored.

It is always said when issues such as this arise that it is a question of systems failure, but if we continually blame the system, we will never start to address the problems that may be endemic in organisations in people not believing they have responsibility or accountability when things go wrong. As evidenced by HIQA's report and given the testimony of our guests, there was sufficient information flowing from them, others and staff at the hospital to senior management at local and regional level to suggest it could not state it was unaware of the inherent dangers in maternity services and the hospital.

I do not want to ask a leading question, but did Mr. and Mrs. Molloy ever believe the HSE was genuinely interested, or was there a pretence that it was trying to assist and listen to them? Did they always believe barriers were being placed in front of them or did they have the sense that the HSE was genuinely interested in listening to what they had to say and trying to address the problems they were highlighting in the context of their tragic case and broader services at the hospital? Do Mr. and Mrs. Molloy think they were led up the garden path by delays and prevarication in the hope that they would eventually go away or was genuine empathy shown at any stage in the process?

None of us would be here today but for the tenacity and bravery shown by the families concerned. Equally, however, if "Prime Time" had refused to take the telephone call from the Molloy family, HIQA would not have carried out an investigation of Portlaoise. This is a matter of concern for me because when families undergo terrible experiences, I would expect the system to kick in with a thorough analysis of what went wrong and how it can ensure such experiences do not happen again. Ms O'Connor's comments on the interaction between Patient Focus and the HSE in advocating for patients who were damaged by the health services suggests an inherent resistance to openness. This committee has previously discussed the question of developing transparent policies for dealing with patients who have had adverse interactions with the HSE. These policies do not seem to be progressing. The correspondence between the HSE and Mr. and Mrs. Molloy suggests this attitude lasted almost until the broadcast of the "Prime Time" documentary. This attitude is also evident in the chief medical officer's report and recommendations on Portlaoise. It should be a cause of significant concern for anyone who wants the HSE to provide safe maternity services that some of these recommendations have not been implemented.

Do the witnesses believe the HIQA report reflects their experience of dealing with the HSE in regard to the immediate problems with maternity services and the death of baby Mark and their subsequent dealings with local management? Do they think the report is deficient in any aspects? It is clear that alarm bells were ringing in the hospital for a number of years. Last week representatives from HIQA told us they had been investigating the hospital. I asked why HIQA did not carry out an investigation prior to being requested by the Minister for Health to conduct a full investigation under section 9 of the Health Act 2007. Can we learn anything from this sequence of events? What should be done to ensure the witnesses' experience is not visited on any other family not only in terms of the provision of maternity care but also in the subsequent experience of engaging with the health service?

Do the witnesses believe a statutory patient safety authority could play a meaningful role

in facilitating other families who have had adverse encounters with the HSE to come forward with their experiences? Have the Molloys encountered any significant change in their dealings with local management at Portlaoise hospital between the time of baby Mark's death and the present?

Deputy Caoimhghín Ó Caoláin: I join the Chairman in welcoming the witnesses and thank them for their contributions and written submissions. I am very conscious, as we all are, of the great pain the families have suffered, but we are also conscious that there are many others who will watch these proceedings either now or perhaps later as the day progresses. We send our sympathy to and express our solidarity with all of those families, some of whom I know personally.

On the statements which have been read, I will make a number of points and ask some questions.

Chairman: I am sorry to interrupt the Deputy, but I forgot to do this at the beginning. To help the families, I ask members to indicate when they are putting a question. I will take three members together as it might be difficult for our guests to take notes.

Deputy Caoimhghín Ó Caoláin: That is helpful. Mr. Molloy made the point that it had become apparent to him at an early stage that his was not the only family whose healthy child had died in similar circumstances. How did it become apparent? From what engagement did it become apparent? How did it come to his attention?

Mr. Molloy made a point about each new level of management as he progressed from local and regional to national level and said it was clear to him and Ms Molloy that they appeared to be totally unaware of the serious patient safety issues involved. Did he believe that that was the case? Were they being less than upfront and honest or does he believe, therefore, that there was a suppression of the facts and the information at a level closer to the hospital and that it was not making its way up through the structures?

I refer to the point made about the engagement in October 2013 and I am conscious in referring to it that the experience of Mr. Kelly and Ms Delahunt happened earlier that year when they lost Mary Kate in May, a full 15 months following Mr. Molloy's tragic loss. There was the further case of the Redington couple and that of another couple. Apart from the known number of losses, there were a multiple of cases in which bad outcomes were a reality. While I do not in any way seek to reduce attention on the fact that five babies were lost, lives were also seriously impaired in a significant number of cases. Can he shed further light on this?

Mr. Molloy's decision to go to "Prime Time" was triggered by a meeting with the HSE national director for quality and patient safety and the HSE national director for patient advocacy. Can he identify whom he met? If he cannot, I will understand, but the two positions were national director for quality and patient safety and national director for patient advocacy. Despite the fact that the purpose of the meeting was to discuss implementation of the 43 recommendations contained in Mr. Molloy's report, all they had to say to him was that they were there to listen to him. That is not a discussion. That was totally and absolutely outrageous. In some way, their almost monkey-like see, hear, speak, know, etc. approach has done us all a service because it was the trigger that directed him in his frustration to go on the national airwaves, for which I thank him sincerely.

Mr. Molloy's closing comment about an attempt at both local and national level to sup-

press repeated known red flags is a very serious matter. Many of us are parents and have gone through the experience of childbirth either as the woman or as a partner in support. This is of major importance to each and every one of us and for our children, who may become parents in their own time. It is very important that the learning takes place.

I refer to what Ms Delahunt said, which was very important, about the extent of funding being directed to legal voices to limit inquests scopes and, most importantly, therefore any derived learning. I am making the link between both points by Mr. Molloy and Ms Delahunt because it is the learning that needs to happen. It needs to inform a system that is clearly deficient in so many ways.

That is not to take away from the many excellent people who work in maternity units throughout the country and are giving a first-class service, but there are deficiencies. There are clearly deficiencies within the reporting process and the address of these exposed deficient practices by virtue of the fact that there is no learning taking place. The sad reality is that any of the witnesses' experiences could be repeated today in any number of settings as a consequence. Therefore all the more important it is-----

Chairman: The Deputy is up to seven minutes.

Deputy Caoimhghín Ó Caoláin: I will close with a last couple of points. I thank Ms O'Connor for her contribution and I commend, as I always have, the work of Patient Focus. She listed a number of hospitals throughout the country that had contacted Patient Focus, following the RTE "Prime Time" programme. She added a very important point about which some of us as members of this committee had been concerned heretofore, which is that these incidents and concerns are not confined to hospital maternity units outside major urban areas. She stated, "There were serious complaints too about care at the three major Dublin maternity hospitals". I ask her to elaborate on that because it is very important. There may be a section of the community which says this is only about Portlaoise, Cavan, Portiuncula or whatever, but it is an issue that every citizen, and in the first instance every mother and prospective mother, should be exercised about. It is imperative that this is addressed universally across the board. I ask Ms O'Connor to elaborate on that.

I refer to the delay in the publication of reviews, as highlighted in Mr. Molloy's report. There was a delay even in the HIQA report with a possible further delay in terms of threatened legal action with the possibility that it would not proceed. I am deeply concerned in my constituency that even though we have had four tragic outcomes, just one fewer than the experience in Portlaoise, we have still to see published a single report on any of those, going back to baby Jamie Flynn in November 2012. That report was suppressed through the courts. The second report is yet to show.

What of the internal HSE address of the tragic outcomes in April and May 2014? We are a full 12 months on. How long does it take for the learning process to get under way? The publication of speedy reports is vital. I ask Ms O'Connor to elaborate on that.

I offer my sincere thanks to all the witnesses.

Deputy Seamus Healy: I am conscious of the fact that there is a large number of members present who wish to address the committee on this issue, so I will be as brief as possible. I thank our guests and welcome them. I sympathise with the families. We owe them a debt of gratitude for highlighting these issues in difficult circumstances and against all the odds.

The HIQA report is shocking. It is difficult to believe the degree of failure at all levels throughout the service, local, regional and national. It appears that, at each level, the families were deliberately blocked when trying to establish what happened in their circumstances. Previously, I raised a question that needs to be asked again and needs to be answered, that being, whether the HSE is fit for purpose. Is it fit to organise and maintain medical and hospital services? Undoubtedly, the report is a damning indictment of the HSE at all levels.

I have one or two questions. Are the families happy with HIQA's report and recommendations? Are there recommendations that are not in the report that the families want prioritised? The report is excellent and shocking, but it has at least one deficiency relating to the recommendation on advocacy. I am strongly of the view that there should be an independent statutory advocacy agency or authority. It should also be independently funded. I am not criticising Patient Focus, but many advocacy agencies - I have been through this issue in terms of mental health services - are funded through the HSE. An independent statutory authority that is funded independently is necessary to ensure patients are properly represented. How does Patient Focus view this issue?

Chairman: I am conscious that four committee members and one non-member have indicated. I will hand back to Mr. Molloy and whoever else wishes to speak.

Mr. Mark Molloy: Regarding Deputy Kelleher's first question on whether the HIQA report reflected our experience, it does absolutely. For me, what jumped off the page straight away was the fact that the HSE was aware at local, regional and national level that this was an unsafe unit. Members saw from the schedule that I went through that we had been screaming about this for 18 months through meetings and so on but the HSE did nothing about it.

The HIQA report reflected a dysfunctionality in various management levels, particularly regionally. We met various people who seemed almost unaware of the HSE's policies and procedures in the investigation of an adverse event such as our baby's death. They genuinely seemed not to know how to handle this investigation in accordance with their procedures. In that regard, the HIQA report reflects exactly our experience during the period from January 2012 until publication of the report.

Ms Róisín Molloy: It is important to note that we met with officials at every level, to whom we believed we were bringing new information in regard to what was happening at each level below. We met with management, who told us there were no policies or procedures in place which allowed for an investigation into Mark's death. Our response to that was, "Oh my God" because we knew that was not true. We then raised at regional level local management's opinion in regard to its carrying out an investigation into Mark's death. We knew fairly soon into the process that people were only paying lip-service to us. While during many meetings people were very emotional when apologising to us and saying that they were sorry about our son's death no action was being proposed. What we wanted at that stage was an acknowledgement of Mark's death and the seriousness of it and to prevent this from ever happening again. However, the importance of learning from Mark's death to ensure this did not happen again was completely lost on every member of the HSE. We kept going. We utilised the HSE's systems to have Mark's death investigated and to highlight patient concerns in Portlaoise hospital. We followed the HSE system, from which the HSE constantly departed.

Mr. Mark Molloy: In regard to the point about alarm bells ringing with the key stakeholders, I have previously made the point, although not here today, that I do not believe anybody involved in this area has covered themselves in glory. We know that the State Claims Agency

highlighted its concerns about the hospital in 2007 and that the INMO, on behalf of the midwives, had issued letters stating that the unit was unsafe and that a baby was likely to die as a result. The Department of Health and the HSE were also clearly aware of the situation as, I am sure, were various other interested parties. However, there was no coming together of that shared information. The issue for the State Claims Agency was whether there was underreporting at Portlaoise hospital because it was not receiving as many reports about it as it was receiving in relation to other units. However, there was no coming together of the agencies on the issue. There are many stakeholders in this country involved in providing us with a decent health service, all of whom knew what was going on. They had a far greater platform than Róisín or I to tackle this issue yet all they did was issue a couple of letters about it. That is not good enough. Every key stakeholder in this country involved in the health sector needs to get involved in this if it is to be properly cleaned up.

In regard to the question about local management change at the Midland Regional Hospital, Portlaoise, I will never again set foot in that place. To be honest, I have no idea if there has been any change.

Ms Róisín Molloy: Deputy Kelleher asked about HIQA investigating individual complaints. We highlighted our concerns to HIQA but it does not have the power to investigate individual complaints. We thought at that stage that we were on our own. It is difficult to have individual cases addressed. It later became apparent that we were not on our own and that there were numerous other cases.

Chairman: How long did it take the witnesses to establish that they were not on their own?

Ms Róisín Molloy: I have been told that it is normal in such situations for people to go into shock and that, when grieving, people can be stunned into silence. Unfortunately for the HSE, I went in the opposite direction and became the crazy mother telling everybody that my child had died when he should not have died and highlighting safety concerns in regard to the maternity unit at Portlaoise hospital. People then started sharing their stories with me. Baby deaths is not an issue that, I believe, people like to talk about. Neither Mark nor I would have talked about it. It is an issue people are not happy to talk about. However, when I started talking about it, it became apparent that there were other people in our local area who had not only experienced deaths at the hospital but had had very horrific experiences there and were treated similarly to us.

On the issue of baby deaths, we became familiar with two local people who had had a similar experience to ours, whose experiences are not in the public domain. I then heard the interview on the radio with Joshua Keyes' mother, Shauna, following which, when doing research into how I could have baby Mark's death investigated I came across a paper in the UK on Nathan Molyneaux's death. At that point, we knew that we were not on our own.

Mr. Mark Molloy: Deputy Ó Caoláin asked about each new management level and if we were aware of them or believed them. Very early on, as Róisín will say, we were very upset at these meetings and we would believe anything we were told. We had to learn to swallow it if we were to get some answers. We came away from many meetings saying, "That is it now, somebody is going to learn from this, we will get answers, it will be great". Suddenly, weeks would go by and there would be no answer or action. Once the Savita Halappanavar story broke, we knew there was a reaction. Mark had died nine months earlier and the HSE had told us we could not do this or that and policies had not stated this, that or the other. Suddenly, there was a total departure and an *ad hoc* reaction to Savita's death. It took ten weeks to nominate

an obstetric consultant externally for Mark's investigation and it took four days in Galway. Mr. Praveen Halappanavar's account of events were seen as central but we were not allowed participate in Mark's investigation.

Chairman: Will the witness explain what he means in saying "not allowed"?

Mr. Mark Molloy: We were told it would be based on the clinical notes and interviews with staff. These were clinical notes we had already proven were changed. We had the before and after. Somehow we got those. Eventually, our input was linked to a chronology of events. It took six attempts for them to transcribe what I sent in. They kept taking poetic licence with what I was sending in. We went back and told them it was not what I said and that I had said something else. Eventually, it was right.

Chairman: Was that written testimony?

Mr. Mark Molloy: Correct.

Chairman: You were not invited into a room to have a conversation.

Mr. Mark Molloy: We had that as well. Originally, we asked if this could be given over the telephone because we were given a very short timeframe to respond. We were told it had to be submitted in writing by a particular date. We worked through a 36-hour session and submitted it at 11.56 p.m. one night to get it in on time and meet the HSE date so it would get back to us on time. The HSE just dragged it out.

When the Savita Halappanavar story broke, it became very apparent to us that we were being paid lip service and being dragged along. I described this in the past as an attrition policy. Eventually, if people are worn down, they will go away. We got to that stage a couple of times. We were asking questions and sending an e-mail at 4 a.m., saying, "Jesus, we cannot do this any more". I will get upset when I say this but Mark hung on longer than he should have to be born alive, the one minute of life he had. We said there was no way we would give up on it.

Ms Róisín Molloy: To back up what Mark said about our involvement with the HSE investigation, the executive's policy indicates that families would be encouraged to take part with regard to a chronology. In reality, it does not work like that. It is like a token participation in an investigation. It should be noted that Mark's investigation is the only one of its kind into a baby death in Portlaoise hospital. The rest of the investigations were reviews done internally, and the parents did not have any knowledge of them. As yet, it is the only report into a baby death at Portlaoise hospital and we drove that report to completion. It should also be noted that one of the external experts brought in by the HSE did not get our account of our labour but just the chronology. The notes used were the changed notes and the copied notes were not used in the investigation. We only received a copy of the original notes under freedom of information after the "Prime Time" programme. Through a HSE investigation and inquest, the notes used were the doctored notes. If we had not driven and forced the process, Mark's report would never have been finalised-----

Chairman: Could I just advise you to withdraw the word "doctored", if you could?

Ms Róisín Molloy: I am sorry. I withdraw that. The notes were changed.

Chairman: Thank you.

Mr. Mark Molloy: At Mark's inquest, the particular person giving evidence did say that he

changed Mark's notes six days after Mark's death. He said it at the inquest in Portlaoise.

Chairman: We will have representatives of the HSE in later and we will put that to them. I am sure it will be part of that discussion.

Mr. Mark Molloy: Deputy Ó Caoláin asked about bad outcomes. We are speaking about five baby deaths.

At the meeting with the Minister for Health, Deputy Varadkar, on Wednesday in Portlaoise, there were 120 people in the room. Person after person told stories of their baby's death or cerebral palsy injury or horrific injuries that mothers were left with. This is not a figures game but the figure is far in excess of five baby deaths. People spoke of 1986. Two babies were lost to one couple in 1997 and 1998 while another couple lost two babies in the 2000s. Right through that period, including the boom years when we had a few bob, this was going on. A consistent theme emerges throughout. People were told: "You are the only person this happened to. You are very unfortunate. Go away, you will have more children." The same theme emerges and the number is far more than five babies.

Ms Róisín Molloy: On that note, it is advised that medical staff notify the National Perinatal Epidemiology Centre, NPEC, in Cork of incidents as it collates the statistics on baby deaths, near-deaths of mothers and maternal deaths. It should be noted that Mark's case was not reported to the NPEC. Mark was wrongly classified as stillborn even though he had been born alive. He was not reported to the NPEC and had we not pursued that issue and had it changed, he would not have appeared in any of the statistics. That is why we have strongly argued that there is a need for proper statistics and real figures relating to maternity services in Ireland. Such statistics cannot be based on volunteered information when there are babies missing.

Mr. Ollie Kelly: I join Deputies in congratulating the Molloys on what they have done. Unfortunately we are here as evidence that management and staff of the HSE failed to listen or to follow recommendations from inquests and from the report into baby Mark's death. Had they listened, our little girl would be here today. So too would baby Síofra and the damage done to another little baby would have been avoided. It has been tough on us to come in here today. I ask Deputies to bear with me because I am a little nervous.

We, like all other families, were led to believe that we were the only ones. I have heard Mark and Róisín Molloy speak about trying to make the services better. We met hospital representatives in December after Mary Kate passed away. They led us to believe we were the only ones and that they never wanted to see anything like this happen again in Portlaoise. We found out later, through the investigation into Portlaoise, that there were many baby deaths. In the period between baby Mark's death and the death of Mary Kate, another baby died. Ours is known as the fifth case but another little girl died in November 2013.

At all levels there were opportunities to learn, flags being raised and alarm bells going off but they failed. They failed us and they let us down unbelievably when Amy went into that hospital. A hospital is supposed to be a safe place; it is where you go to be cared for but she was not cared for. The fact that management knew that the hospital was unsafe but let that continue is unforgivable. Deputies spoke abut Cavan General Hospital and other hospitals throughout the country. The HSE has governance over all of the hospitals but it let this happen. That is so hard for us to cope with.

Mr. Mark Molloy: I wish to back up something Mr. Kelly has said by referring to the e-

mail schedule I went through earlier. It answers the question as to whether the HSE is fit for purpose. I will not mention any names but one of the e-mails reads as follows: "I know you are aware that the high rates of harm that I allude to are reflective of what is occurring in other jurisdictions also." I stress the phrase "high rates of harm" as opposed to the "best" and "safest" country in the world in which to have a baby. The reference is not to "average" but to "high" rates of harm. This e-mail was written in December 2012 by the people who are responsible for the safety of all hospital services, not just maternity services, in Ireland. That was the way those who were responsible for safety in all hospitals, not just maternity hospitals, spoke about this in December 2012, five months before Mary Kate died. It was absolutely disgraceful.

Deputy Mary Mitchell O'Connor: Who said it?

Chairman: We will deal with that matter in the afternoon.

Deputy Mary Mitchell O'Connor: Was it a doctor?

Chairman: We will not do that now; we will leave it until the afternoon.

Deputy Caoimhghín Ó Caoláin: Is that the answer in identifying the two senior directors? Does Mr. Molloy feel he is not in a position to identify them today?

Mr. Mark Molloy: I suppose so.

Deputy Caoimhghín Ó Caoláin: Nevertheless, it is not beyond our gift to establish who they were.

Mr. Mark Molloy: It is one national role.

Deputy Caoimhghín Ó Caoláin: Thank you, Mr. Molloy. Is it possible Ms O'Connor might respond to the questions put to Patient Focus?

Chairman: Yes, but I am conscious that seven other members wish to speak.

Ms Sheila O'Connor: I will be brief. I think HIQA's report reflects exactly what happened in the Midland Regional Hospital, Portlaoise, but I will go a great deal further and say it probably reflects what happens in most hospitals in the country. I was horrified at and shocked by the reaction of the HSE a couple of months back to the imminent publication of HIQA's report and its denials of patient stories, as if they were fabrications. They were the same stories we had heard morning, noon and night during the course of the past two years. For the HSE to imply that the parents were wrong, that they were over-emotional and that there was a lack of due process is an absurdity. I really find it very difficult to take that on board.

The structures in the hospital clearly had not worked. What both families are saying about the complaints process is correct. When Mr. Mark Molly said he and Róisín Molloy had got a good review, they were correct. In fact, they got a spectacular review in comparison to any other patient that we in Patient Focus had ever dealt with. That was as a result of their tenacity and courage in standing up for their baby. In our opinion, it is undoubtedly true and I do not think anybody who knows anything about this can contradict that view. It is totally true. Ms Róisín Molloy gave a description of being considered a crazy mother. If we had one pound for every time we listened to a patient tell us that they were considered to be "a crazy person, that I am this and that", Patient Focus would have a great deal of money. That is the standard reaction to bad events in a great many hospitals in the health care system. Sad to say, but it is true that the issue of safety is not taken seriously. It is a Cinderella process within the HSE.

It is not true to say HSE personnel do not listen. They certainly do listen and hear, but they do not take on board, emotionally or psychologically, what is said. It is a self-defence mechanism that clicks in when they hear about terrible stories and they feel at some level that they may be or held personally responsible. They want to be able to go home and sleep at night; therefore, they do not take it on board.

On what should happen in terms of accountability, I have concerns, as one frequently finds, that the good people leave. I was very worried about the incentivised retirement scheme for HSE employees a number of years ago. It is true to say, from the experience of those involved in Patient Focus, that the best people, the ones who had supported Patient Focus, walked out the door. They have got jobs in other areas since, which is a terrible loss to the system. The people most interested in patient safety took a hike. I do not know if my colleague, Ms Molloy, agrees with me, but I think that is true. They were quality people who could go elsewhere.

People in the HSE have no power and the description of the complaints process brings this into stark relief. The complaints process is about following due process for staff; it is not really about finding out what happened. That is the reason it takes so long. People get up on their horse, go to the trade union, professional bodies or lawyers, or they go sick. Every single possible strategy an individual can use to delay things is used. This should be about finding answers for people who have had dreadful experiences, but it is not. That is the reason external reviews should be conducted and answers provided quickly for those who have had bad experiences. That is not too much to ask.

The health care system is spectacularly bad at dealing with bad events. I do not know what that comes from, but it is part of our culture and history. It is part of the major power structures still within society and the general population are perhaps afraid of them. In the health care system there is a dependency relationship between the patient and the professional and the one thing people do not want to take on board is the fact that perhaps they were let down by their professional. It is incredibly difficult to take this on board. I do not wear hats, but if I had one, I would certainly take it off to the families here. The Molloys jumped on board immediately and sussed out exactly what had happened. Emotionally, it is incredibly difficult to do that and remain intact psychologically.

There were a few other questions. Deputy Caoimhghín Ó Caoláin and others raised the issue of a patient safety agency. Patient Focus has always been in favour of having a statutory patient agency authority. I was on the board of HIQA for a number of years and during that time I grew to have huge admiration for the former CEO. The other day I saw Mr. Phelim Quinn on television at the launch of the report and, to be honest, I thought to myself, "I would not like to get on the wrong side of that man." That was my gut feeling in terms of his body language and demeanour. That is my personal view which I have not discussed with anybody in Patient Focus. Mr. Quinn means business in bringing about a cultural and mindset change in the health care system in Ireland.

Things are much worse in private hospitals.

Chairman: That would be for a different forum.

Ms Sheila O'Connor: My apologies. On advocacy, HIQA does not have authority to look at individual cases. I believe HIQA was very concerned at the prospect of a patient agency dealing with individual cases and how it would impact on its role. Perhaps that is something people should consider in the context of setting up a separate statutory agency. Perhaps Ms

Cathriona Molloy might like to contribute something now.

Chairman: Is that okay or do the delegates want to take a break?

Ms Cathriona Molloy: The day the "Prime Time" investigation unit's report on the HSE was broadcast, 31 January, was a very sad day for me because it was 18 years on from being a patient of Dr. Neary and the fact that these incidents were happening was very emotional. As Ms O'Connor can tell the committee, on that day I had a row with the HSE because it had not published information on a helpline. RTE wanted information on a helpline to be put up that night, but the HSE refused to do so because it stated not many people were affected. We had no choice but to put up the Patient Focus number and there was a row because we did this. We worked all evening and all-----

Chairman: Where did Patient Focus publish its number?

Ms Cathriona Molloy: We put up the Patient Focus number on RTE. As soon as the programme was over, we got an e-mail every time somebody left a phone message. The e-mails were flooding in and it is difficult to express the grief shown in them. We were shocked by the response and the fact that the HSE did not recognise it is scary. The battle patients face to get answers was wrong and disgraceful. The balance of power is weighed towards the professionals, not patients. It is those who are investigated who are listened to. Blocks are put in the way of those seeking answers.

I met Róisín and Mark Molloy in June 2012. When I returned home the next day, a Saturday, and spoke to Ms O'Connor on the telephone, I told her that there were problems in the hospital. I said the same to my husband, who came with me that day. I said I was extremely concerned about the situation because it was like hearing similar stories all over again. I took two memories away with me that day. The first is of listening to Mark describe standing in the theatre when baby Mark was being born and the second is of Róisín sitting on the stairs waiting to get a letter with answers. How can that be justified by anyone?

Patient Focus has been doing this for such a long time and we know that there are complaints in all maternity and general hospitals and the community. Ours is a small organisation of four people with a very limited budget. We do the job on a shoestring and the only reason we do it is we are passionate about it. A person could not do this on a nine-to-five basis. We work nights and weekends and jump to the support of people because that is what we want to do. Then we hear what happened to Ollie and Amy, Joshua Keyes and baby Katelyn. To be clear, the way we found out there were two other reviews carried out at Portlaoise hospital of the deaths of Joshua Keyes and baby Katelyn was through the legal process of the inquest. The HSE's barrister had to hand over the reviews. He handed over the one that mentioned baby Joshua, but the others were blacked out. We knew that there were two other babies, but families were not notified. When the "Prime Time" programme was broadcast, they were told it was because of social circumstances that they were not told. Everyone has a right to be told if there is an adverse incident.

This committee has power. It must never allow this to happen again. It is just not on and not good enough that this continues to happen and patients have such little power.

Chairman: I thank Ms Molloy. I will take the next three speakers and then go back to the delegates. We will then hear from three further speakers and two non-members. I ask members to have questions rather than commentary because there is a lot to get through. I call Deputy

Mary Mitchell O'Connor, Senator Colm Burke and Senator John Crown in that order.

Deputy Mary Mitchell O'Connor: I thank the parents so much for coming. We have had different groups here, but this is probably the most harrowing day we have had. It has been mentioned that a hospital should be a safe place and I understand it should be safe. At the same time, there is human error and things happen that should not. I get the feeling that none of the delegates wanted to blame anyone in particular on the day, yet they have been treated so badly. Will they comment on this statement?

Mr. Ollie Molloy perhaps said it all when he said he had come to give his evidence and asked what would happen next. Those working in theatres and maternity units where babies are being born should do their jobs to the best of their ability. Things happen and things go wrong, but when it is over, there should be a no-blame policy. People should put up their hands and not drag parents, patients and others through the courts. The delegates said they had to use the freedom of information regime to get answers. They have been treated appallingly. What is really sad is that there are many other patients who have been treated as badly.

I asked last week and ask again now what, in the name of God, the people on management committees at local level were doing. They seem to be reporting to a hospital committee. We can blame the HSE. By God, it is not covered in glory and its representatives will be here later. However, if something can come out of this process, staff in hospitals - doctors, nurses, anaesthetists, whoever they are - should do their jobs and if something goes wrong, they should have empathy and deal with people in a humane way. When a woman goes into hospital to have a baby, she is so vulnerable and expects people to help her. She needs help. The people in question are all paid. This is not voluntary work and many of them are well paid. They should do their jobs professionally and when it is over and if mistakes have been made, they should, at least, treat people humanely and with empathy rather than covering up, running for cover, being afraid of being sued and so on.

Senator Colm Burke: I thank Mr. Mark Molloy, Mrs. Roisín Molloy, Mr. Ollie Kelly, Ms Amy Delahunt and Ms Sheila O'Connor for their presentations. I know that matters have not been easy for our guests and that the past three and a half years have been tough. I hope the fact that they have managed to reach this point means that a great deal will be achieved in ensuring change.

I wish to put a question to Ms O'Connor of Patient Focus in respect of the reference on page 71 of HIQA's report to a 2006 review of the maternity department at Portlaoise hospital, which identified the need to appoint more midwives and clinical midwifery managers. This recommendation was not acted on until 2014. Given her experience of dealing with patient complaints, does Ms O'Connor find that understaffing and the use of locum and agency staff are contributory factors in many of the issues affecting the health service? I accept that I am moving slightly away from the matter under discussion, but eight years passed until there was a reaction in respect of the 2006 review. Are difficulties arising because too many locum and agency staff are being employed and as a result of the fact that not enough is being done to plan for the appointment of sufficient numbers of permanent staff?

Ms O'Connor referred briefly to the voluntary hospital sector. Does she find that a clear line seems to have been drawn between management within the HSE and medical and nursing staff in trying to deal with and manage complaints? There are certain people who seem to be prevented from dealing with complaints and actually should be on the front line in this regard. As a result of their absence from the process, inadequate explanations are being given. This

would not be the case if all of those involved worked together and if a line such as that to which I refer had not been drawn between them. Will Ms O'Connor indicate whether there are differences when it comes to dealing with complaints relating to HSE hospitals and those involving voluntary hospitals? There is a master in each of the three maternity hospitals in Dublin and, in real terms, the buck stops with these individuals. Is there a significant difference between the HSE and the main maternity hospitals in Dublin?

The report before the committee highlights the problem of understaffing. During the past three to four years I have consistently referred - I apologise for doing so again - to the Hanly report of 2003, which clearly set out that there should have been 190 obstetricians and gynaecologists in the health service by 2012. On paper and according to the HSE there are 133 such professionals operating within the health service. In fact, there are only 104 whole-time equivalents. Is Ms O'Connor of the view that there is a need to expand the role of nursing staff and midwives and appoint more consultants rather than relying on the services of junior doctors?

Senator John Crown: I extend my sympathy to the bereaved and those who have suffered such terrible losses. I cannot begin to imagine the pain they continue to experience which has been compounded by certain factors which came into play following the deaths of their children. What they have endured is simply horrific.

I am terribly sad about the position in which our guests find themselves and I am also somewhat despondent about the remedy on offer. I have been back in Ireland for 22 years and it is apparent to me that there are really significant problems with the health system which I have been trying to highlight for a long period. The committee will be discussing this matter later in the afternoon, at which point I will be asking some very hard questions and making a number of extremely tough suggestions.

The notion of a cover-up is absolutely plausible to me. I have seen evidence of cover-ups within the health system on many occasions. A year after I returned to Ireland I discovered that the cancer service here was utterly abnormal by any international standard and began to make waves about the matter. Serious attempts were made to shut me up and have me disciplined or even fired. If I had not been operating under the old consultants' contract, after completing the first year in which I had security of tenure, I have no doubt that I would have been fired. I recall going to meetings with senior figures of the Department of Health when this became a big news story after two or three years and I started rattling the cans. I was told they would try to do something about it but that I must shut up. I must not go public about it because the Minister did not want to read any more accounts about people dying unnecessarily from cancer treatment. When the Limerick cancer services disaster happened, a doctor on the ground, who saw real problems with the service, went to the Department of Health a long time in advance of it becoming public. The person in question had a position of responsibility in the Department and is someone who has often sat in these chairs. Nothing was done, though, and the doctor was subtly threatened. He was told that the course of action he was taking was inappropriate and it was suggested he should be the subject of disciplinary censure himself for not going through other channels. As a result, he shut up pretty quickly.

Why does this happen? The problem is that the collective health administration, the leadership class in the health service in this country, namely, the HSE, the Department of Health and even HIQA, has a corporatism about it. They see "us" and "them". "Us" are the only non-self-interested party in the whole potpourri of those competing interests who have their paws out for something. They believe they are the only people in the world, not just in the Irish health system, who are capable of acting without self-interest. In fact they do act out of self-interest.

Their constituency is complicated by the fact that, while there are both "us" and "them", there are two different kinds of "them". On one hand there are the "them" who represent the patients who have suffered and who have asked for adequate resourcing and appropriate answers to harsh questions. On the other hand, there are the "them" who are the doctors, nurses and midwives who point out the deficiencies in the system but are dismissed as being shroud wavers. I was horrified to read in black and white today that folks in the Coombe hospital were raising issues which were clearly being ignored.

Where does the responsibility lie for this? I have given the Neary episode so much thought over the years. What an awful tragedy to be visited on people.

Chairman: The Senator's time is up. Also, a telephone is buzzing.

Senator John Crown: It does not appear to relate to any of my material. I do not think it can be my pacemaker. I believe I can give that a few more years. How long do I have? I was told I had six minutes.

Chairman: No. Spokespeople get up to ten minutes, non-spokespeople four minutes.

Senator John Crown: I did not know we had spokespeople. I am sorry. I will finish very quickly. In the case of Neary, responsibility was put onto the individuals who carried out the terrible, awful practice but there was something wrong with a system which allowed somebody to act, effectively single handedly, way beyond their competence and their surgical skills in a hospital which did not have an intensive care unit, a blood bank or any of the things it needed. It did not have appropriate levels of peer review which would have found that there was something wrong with this man and that he needed to be stopped. Not only does the responsibility devolve on him, it devolves on the system.

The case of Savita Halappanavar is telling. When that awful tragedy occurred, two and a half years ago, I pointed out that, from what I had read about it, the hospital in Galway did not sound like an optimally safe place to have a child. The problems were not unique to Galway but it was grotesquely understaffed. It did not have the kind of staffing one would expect in a modern obstetric service, one that hilariously boasts of having the best outcomes in the world when it manifestly does not. These problems were pointed out years ago but what is being done about them?

We can do a number of things. We definitely need a better complaints procedure and an appropriate culture but we also need to fix the system. In the *Titanic* analogy, we need not just a better inspector of lifeboats and not just a better complaints procedure for those who lost someone in the disaster but enough people on the bridge to make sure the ship does not hit the iceberg in the first place. Then one needs to have enough lifeboats in place. Some very hard questions will be asked this afternoon.

I give my sympathies to the witnesses. I cannot imagine what they have gone through and I commend their bravery for coming here today.

Ms Róisín Molloy: Mention was made of human error on the part of the local staff in the hospital. We know that, on the morning of 24 January, no staff actively went into work to cause harm to my child. We do know that human error occurs in all aspects of life. The HSE has a department to oversee that. It acknowledges that human error occurs and that when it happens one has to investigate to prevent human error happening again.

With respect to what happened within the HSE, we had an investigation into Mark's death. The HSE's standard spin in the event of an incident happening is that the review is to establish why any failures occurred and, second, it is to identify the system's causes of these failures and the actions necessary to remedy these so as to prevent, or if prevention is impossible, to reduce the likelihood of a recurrence of such failures as far as is reasonably practicable. Mark's death in Portloaise hospital was not the first and neither was Joshua's death. This has been going on for decades. I can understand that human error can occur but at what stage does someone make a decision not to act? They had all the information there from the State Claims Agency, the doctors and the nurses. The public were trying to speak about this. I can point to the number of parents the other night who apologised and said, "We are sorry we did not keep going with it but we could not do it", and to the number of parents with children with disabilities who said, "We are sorry we could not force it; we could not fight the HSE because we are too busy caring for our child".

The issue here is that there must be collective responsibility. In terms of the medical staff that morning, there are the processes with respect to the Irish Medicines Board and An Bord Altranais. The HSE as an employer had a duty to discipline the staff who had deviated from their contracts or deviated from safe practice. We have already spoken about a doctor who changed his notes. He admitted he changed his notes. The investigation into Mark's death found that to be true. That doctor was never disciplined. No discipline procedures had started to be put in place in that hospital up until recently, up to about three weeks ago. Up to then nobody had been disciplined nor had a discipline process started.

Chairman: To be fair, we will put some of those comments to the HSE later to have balance in this respect.

Ms Róisín Molloy: Yes. On the national issue, the HSE is a huge organisation. In terms of ensuring that human error is not repeated and can be prevented happening again, there is an audit structure, a department, risk management, an advocacy department and a complaints department, which are very well-funded and resourced. They have the policies and had they followed their own policies Mark and Mary Kate would not have died. They failed in their duty to do the job that they were paid to do. They were to undertake audits but audits did not happen in Portlaoise hospital in terms of CTG trace readings. They did not investigate the baby's death. When Mark died they went so far as to ask us: "Do you want us to investigate this? Do you want to be interviewed?"

We met the advocacy team. In one particular conversation with the national director of advocacy, and he was extremely difficult to deal with, he said to me: "Now Mrs. Molloy, you have had your say and you are very good at this, now I will have mine." We were up against the system. They had every legal advice. Every time we sent an e-mail, we got a reply stating: "We are seeking legal advice on this." We felt that pressure. The HSE had a responsibility. It had known. It had a complaints department. Every single one of the parents we met and to whom we have spoken in the past number of years has said that they tried to raise concerns, even down to the basics of: "What happened? Why did my child die? Why was he injured? Why was I left with severe injuries?" Each and every time their complaints were not listened to and they were not logged. There was no sense of getting a pattern here to see can we learn from this. The information was there and they chose for whatever reason not to act on it. That is something that we hope the committee will be able to ask the HSE today. The HSE does have a responsibility.

Mr. Mark Molloy: On the question of people being afraid of being sued, which Deputy Mitchell O'Connor mentioned, and to answer Deputy Crown's question, it may be an issue that

needs to be taken up by the Committee of Public Accounts rather than this forum. Under section 48 of the Health Act, any matter that is or has been before the courts cannot be investigated by the HSE. People were encouraged to sue. We were encouraged to sue.

Chairman: By who in terms of personnel or the HSE?

Mr. Mark Molloy: By the HSE personnel.

Chairman: At local or regional level?

Mr. Mark Molloy: At local level. When we eventually got advice from a solicitor half way through this, the letter came in like lightning. When that happens the HSE stops its investigation immediately. We hear of people having had cerebral palsy settlements after eight, ten or 12 years with no admission of liability. There is no investigation in those cases. If a family has to sue, that links in to the inquest part of the process. The HSE throws money at the inquests, including senior counsel, so we have to counter that. We had to hire senior counsel for Mark's inquest, and then we were left with a bill. The State picks up the tab for the HSE, which is seeking to limit the scope of the inquest, whereas it is left to the family to pick up the tab for seeking the truth. As a result of that a family has to serve papers, otherwise, they are left with bills amounting to hundreds of thousands of euro. Families have no option but as soon as they serve the papers, the investigation stops. As I said, it may be an issue for the Committee of Public Accounts to look into-----

Chairman: We have a report coming on that area as well.

Mr. Mark Molloy: -----because taxpayers' money being used to limit the scope of investigations is a major issue.

Mr. Ollie Kelly: With regard to what Róisín said, it is the belief of all the families that no one in the hospital intentionally went in to cause harm to anyone.

Deputy Mitchell O'Connor wanted to know what the people were doing in the hospital to improve matters. Frankly, they were doing nothing to improve the situation. What they should have been doing was learning from previous injuries and deaths that had occurred even prior to the deaths of baby Mark and baby Katelyn, but they failed to learn from anything.

The Deputy asked how that could be enforced. Accountability is the only way it can be enforced. Accountability will drive performance. If someone has to answer for their actions or, more importantly, their inaction, I believe that will help them to be more productive in their work.

Senator Burke raised the issue of under-staffing. A lot of the problem is under-staffing but it is also the quality of the staff. The doctor failed to read the CTG technology, and our little girl was in distress. The killing aspect of that is that the midwife did so, and through the inquest we found out that if they had acted on that, our little girl would be alive today. That is so hard to take in. The issue of the quality of the staff must be addressed when consultants, doctors and midwives are being hired in that area.

In our December meeting we also asked were staff being shadowed, and the training process that would follow. Another issue I have concerns consultants who work in the hospital for about a year and then move on. When they move on, do the issues the hospital had with them move with them? That is a major concern of mine. This consultant failed to read our little girl's

CTG, and I am afraid he will move to another hospital. Doctors should not be allowed move on to other hospitals, as part of their learning process, until the hospital is confident that all the boxes have been ticked in terms of them being good enough to move on.

On that, like everyone else we had to go down the legal route to force the holding of an inquest because a doctor wrote on Amy's chart, and it remains on it today, that she left the hospital against medical advice. Under no circumstances would she do that. No mother in the world would walk out on their child and to put that down on paper is not right. Amy had to take the stand at an inquest to prove her innocence. I am sorry-----

Chairman: Are you okay?

Mr. Ollie Kelly: I am getting a bit emotional. That is the pressure they are putting on the families. What we are trying to do here, and this is a common theme among all the families, is make sure that this does not happen to any other family, not only in the Portlaoise area but in Cork, Galway, Dublin and nationally. The people who were in charge of these health services must be held accountable for what happened, and they need to stand up and acknowledge that. Their inaction is just not good enough.

Chairman: Are the witnesses happy to continue or do they want to take a break?

Mr. Mark Molloy: I will finish the answer to-----

Chairman: Are you okay to continue or do you want to take a break?

Mr. Mark Molloy: No, I am fine. In terms of what Róisín was saying, no one was reported to An Bord Altranais or the Medical Council throughout 2012 and 2013 with regard to our cases until the "Prime Time" programme and until Dr. Tony Holohan went into Portlaoise hospital, following which there were reports. We were obliged to report a nurse to An Bord Altranais and a doctor to the Medical Council, not the HSE. No one was disciplined by the HSE. I will again go back to the note change. There was evidence during the inquest on the changing of a legal document. He had changed Mark's notes and was not disciplined. The statistics were incorrect. The National Perinatal Epidemiology Centre, NPEC, statistics were incorrect. Mark was not reported to it. A lady contacted Róisín yesterday to say her baby had died eight years ago. When she went to get the stillbirth certificate, there was no record of him.

Ms Róisín Molloy: Gerard was his name. She asked me to mention his name. Anne Griffith is the mammy's name and she actually stuck with the HSE's process and hers is one of the cases that have been brought before Peter Boylan with the HSE. For Anne there is a conflict in terms of her notes and her own recollection of what happened. She has yet to be contacted by the team. In addition, she went to Mullingar to get her baby's birth certificate - he lived for one minute - and was told he was not logged anywhere. He does not show up in statistics. It is still happening and the statistics are still not accurate.

Mr. Mark Molloy: To go forward, regarding staff rights taking priority over patient safety, I referred to the HSE advocacy investigation into the way we had been treated. It commenced in November 2012 and, as we sit here, is not complete. Three people identified in it launched a legal challenge to it in August 2013 and our update each month since August 2013 has been that we will be updated in another month. It has been like that since. Has there been a cover-up? Definitely, every single barrier possible has been put in our path to ensure the *status quo*.

Chairman: Does Ms O'Connor wish to respond? There are five other speakers.

Ms Sheila O'Connor: I will not say much. On Deputy Mary Mitchell O'Connor's comment that people do not go to work to cause harm, that is patently true. We hear it being said all the time. We understand and know it. Were people to go to work to cause harm, it would put it in a completely different category of responsibility altogether and it is almost unnecessary to say it because otherwise, one would be dealing with something completely different.

Senator Colm Burke asked about staffing. We have neither the competence nor the ability to examine staffing levels in units when people come to Patient Focus with complaints; we simply do not. We deal with individual stories; we listen to people; we believe them and put them in the direction of those who can help them to find out the truth. I must acknowledge that, sometimes or frequently, people are wrong, but even in these circumstances, there normally is dreadful hurt caused by the lack of humanity shown to them when they start to raise issues.

As for the issue of locums on which the Senator picked up, it is a big problem. It was a problem in dealing with the cancer issue and is a problem now. It also is a problem in reviews because people are gone. They have left the country or go missing; consequently, people do not find out. Moreover, in respect of Medical Council inquiries, people are in Australia, South Africa or wherever else and this definitely is a problem in getting them to answer.

I agree completely with Senator John Crown when he states Drogheda was about more than a bad doctor or a doctor who was not up to scratch. Clearly, there were enormous system problems and there was a lack of audits, which completely remains the position in the country. I agree with the Senator that the health service is not as safe as it should be. One major reaction of Ms Molloy who was a patient of Michael Neary, when she heard about HIQA's report, was to ask where the Our Lady of Lourdes Hospital inquiry was in this regard. What about all of the recommendations made in 2007? There were recommendations on audits, clinical directorship and the complaints system, but they are missing. Moreover, in respect of the complaints system, in Patient Focus we have frequently believed the systems are at far too junior a level and that one needs people in a complaints office who are able to confront individuals with body language and skills in closing down questions. Frequently, that is not what one gets and the personality-----

Chairman: Does Patient Focus keep an inventory of reports such as the one just referred to, in which recommendations have been made that have not been implemented?

Ms Sheila O'Connor: No, we do not keep an inventory. Patient Focus is patient centred and keeps complete and utterly detailed notes of the story. On how a complaint is followed through, we do not know.

Chairman: On the report we have to hand, the Minister has said he will implement in full the eight recommendations made.

Ms Sheila O'Connor: Each and every one of them has been made in previous reports.

Chairman: I understand that. Is no record kept of what has been done or what has been followed up?

Ms Sheila O'Connor: Nobody does it, until something else happens. Some of the issues that arose in the cancer investigations about which Senator John Crown spoke arise in the case of certain staff such as locums, perhaps, and also in circumstances which I probably should not go into here.

With regard to inquests into the cause of death and the decision to hold an inquest, for example, we need to consider these issues very carefully. They have not yet been touched on to any significant extent.

Senator Colm Burke: With regard to the comparison in dealing with voluntary hospitals and the HSE, is there a difference?

Chairman: Ms O'Connor will answer that question. Senator John Crown may ask one quick question.

Senator John Crown: I would just like to ask-----

Chairman: Is this a supplementary question?

Senator John Crown: I did not get a chance to ask the question the first time.

Chairman: To be fair, the Senator actually had more time than any other spokesperson. I want to be fair to everyone who has been here all morning.

Senator John Crown: My question is for the relatives, whom I am sorry to put on the spot. When they were interacting with professional staff in the hospital and at the critical moments when they believed the problems occurred that led to their tragic loss, approximately how often were they dealing directly with a consultant in a permanent post?

Ms Róisín Molloy: Yes, it was the consultant who was responsible.

Senator John Crown: In most of the visits during the pregnancy.

Ms Róisín Molloy: In all of my pregnancy visits it was a consultant. Although I had gone public, I saw consultants. I had gone private for my previous birth and had seen the consultant each time.

Senator John Crown: I thank Ms Molloy.

Ms Amy Delahunt: I was attending Limerick hospital, but on the day in question when I attended the hospital in Portlaoise, the junior doctor saw me. It was never escalated. He never saw the need to escalate it to a consultant.

Senator John Crown: I thank Ms Delahunt.

Chairman: I will call Deputies Catherine Byrne and Regina Doherty and Senator John Gilroy. I will ask Ms O'Connor to answer Senator Colm Burke's question in one minute when she comes back. I will include Deputies Lucinda Creighton and Sean Fleming as part of this group also. The policy is to take committee members first and then non-committee members.

Deputy Lucinda Creighton: I am well aware of the policy. As the Chairman is well aware, I am not allowed join any committee.

Chairman: I know, but I must state I am not being unfair to the Deputy, in case she thinks I am.

Deputy Lucinda Creighton: I know that and I am not complaining.

Chairman: I acknowledge and appreciate that the Deputy has been here all morning.

Deputy Catherine Byrne: I thank the delegates for being here and allowing us to listen to part of their stories about losing their babies. I have read the report. I was not here for the meeting last week, but I have read the transcript and listened to the playback of it. I learned that the delegates had been treated barbarically. "Barbarically" is the only word I can find having read the report on what happened. Many people have referred to the courage of the delegates in being here. It is more than courage; it is about determination. They have a clear agenda. Mr. Mark Molloy has spoken very well about that clear agenda and said he does not want any other family to have to go through the torture, torment and heartbreak his went through. The delegates, in their capacity as individuals and parents, are here to ensure no other parent will have to go down the road they went down.

As a mother and grandmother, I thank the delegates. I have not had similar experiences, but I recall that when my girls went to have their babies, it was a very difficult time all round. One is anxious when one's baby decides to have a baby and goes into hospital to have it. One spends the night walking the floor waiting for news. It is a terrifying time, not only for the young mother but also for the grandparents.

There is one point in the document that jumps out and which I find very chilling and heart-breaking. It makes me feel sick to the pit of my stomach. I used the word "barbarically" because I felt sick in the knowledge that people could be put through such a process and treated in such a bad way.

One of the things that jumped out of the report was that many women feared having future pregnancies. That is a terrible indictment on any hospital to have somebody leave a maternity unit feeling that way. We know that babies die before or during birth, but it is just tragic when healthy people go in to have a precious gift they were waiting for and not come out with it. The fear of not being able to have a further pregnancy caps it all.

I will refer to a short extract from the HIQA report's summary document because it jumped off the page at me:

> However, it is apparent that, despite overwhelming evidence to indicate that the local management team at Portlaoise Hospital was struggling to deliver the service, there is no evidence to show that the regional HSE managers took effective control of the situation at that time.

To me, that is exactly what Mr. Ollie Kelly said a few minutes ago. There were many people there who would have been able to control the situation and look after it, but they did not think it was their responsibility, or they did not take on that responsibility.

When I listened to the playback on last week's meeting, I heard the Minister for Health, Deputy Varadkar, speak about incorporating the maternity service at Portlaoise into a clinical network with the Coombe hospital and St. Vincent's University Hospital. I heard him say that this procedure is not in place at the moment, but they hope to have it in place. Do the witnesses believe that in future this will help to alleviate some of the difficulties and prevent inaction at Portlaoise hospital for women going there to give birth? Will it help in any way?

Deputy Regina Doherty: I thank both couples for coming in today. I wish to say how sorry I am personally for the loss of their babies. I am grateful, however, for what Róisín Molloy described as turning into a "mad mammy" and not going quietly. Otherwise we would not be sitting here with her today. The system and process failure would be bad enough if there had not also been a systematic and intentional cover-up over the past four years at every level

of organisation in the HSE. I am so ashamed by how they and others have been treated. The only commitment we can give is that we are four-square behind the witnesses to ensure that whatever the committee can do it will do.

Róisín and Mark Molloy have detailed chronologically all of the correspondence. I want to ask them specifically about their meeting with both Philip Crowley and Greg Price who are directors of the patient safety authority directorate and the patient advocacy authority. They are the two most senior people in the HSE for the matters we are talking about. Róisín and Mark Molloy had a meeting with them to discuss their experience. Can they describe that meeting, including how they were treated and how they felt? What were the outcomes of the meeting? Arising from that meeting, what actions were agreed by Mr. Crowley and Mr. Price? Have those actions taken place so far?

Senator John Gilroy: I welcome Ollie and Amy, and Róisín and Mark. They have my deepest and profound sympathy. I also welcome Sheila O'Connor and Cathriona Molloy from Patient Focus. It is terribly important that they are here today because while the HIQA report makes for powerful reading, the testimony we have heard gives an insight that nothing else could achieve. I salute them for that.

Ms O'Connor said that Patient Focus has four staff and is funded by the HSE. There seems to be a rather compelling case now that Patient Focus should not be funded by the HSE, but should have some independent funding.

Did Ms O'Connor say it was her understanding that funding towards advocacy in mental health services has been reduced?

Ms Sheila O'Connor: It has gone.

Senator John Gilroy: I am a psychiatric staff nurse myself and have worked in the service for 30 years. I noticed that when advocacy was brought in, in parallel with the new Mental Health Act, the culture changed overnight at all staff levels. It was remarkable how the culture changed overnight when there was outside scrutiny.

Mrs. Róisín Molloy alleges that case notes were changed. I do not want Ms Molloy to comment and I am choosing my words very carefully. It rings very true to me because when I was working in the system there was never a top-down order to secure the case notes where there was an adverse event, it was rather a convention among colleagues. The first thing the nursing staff would do was secure the case notes. We used to lock them in a drug trolley. Is it not incredible? I just wanted to record that without further comment.

There seems to be a complete lack of leadership at every level across the HSE. When we think and talk about the HSE, it is normally about our faceless officials. I am not just talking about them, but about our nurses, doctors and staff at every level. There seems to be a blame game culture within the entire service. I remember at a debriefing one time a senior clinician came to me and said "If you had done this, this would not have happened" while pointing at me. Yet, this was a no-blame debriefing. These are the sorts of issues. Do the witnesses think that mandatory reporting of infant deaths is vital? The Minister was here last week and he reminded us that four different agencies are responsible for the collection of data in this area.

Mr. Molloy set out 33 items of correspondence with the HSE, which translates into many hours of meetings and extensive consideration of information and reading. How did Mr. Molloy feel when the report was published and there were early media suggestions that the HSE

was threatening to bring HIQA to court over it? Did Mr. Molloy get a sinking feeling and did it surprise him?

Deputy Lucinda Creighton: I thank all the witnesses for their clear evidence to the joint committee. I am caught somewhere between being utterly depressed and very inspired by the commitment, tenacity and sheer doggedness of the witnesses in pursuing this on behalf of their babies. I have two questions. Mark and Róisín spoke about the report that was conducted about baby Mark. Other reports were conducted internally about which the parents were not even informed which I find deeply shocking. Has the HSE committed to conducting similar reports to the one that was conducted about baby Mark at the insistence of Mark and Róisín? Do the witnesses expect that other reports into those individual cases will be conducted which will involve participation by the parents, which is self-evidently a step that needs to be taken?

Specifically, I ask about remarks Ms Amy Delahunt made. It is up to the witnesses as to whether they wish to respond. Ms Delahunt said the director general of the HSE must stop misinforming the public that these events were before his time at the HSE. It is a very serious statement. I would like the witnesses to elaborate on some instances of that misinformation being given. This is very serious in terms of the persistent and consistent approach of the HSE at the very highest level. We are aware that the HIQA report has identified systemic and other failures at national, regional and local level. Unfortunately, the HIQA report does not suggest who is responsible and who should be held accountable. I would like to hear from the witnesses who they think is accountable or how they consider that accountability should be achieved.

At the end of the process, what will give the witnesses, not personal satisfaction but reassurance that others will not have to endure the trauma and tragedy their families have suffered over recent years?

Deputy Sean Fleming: While I am not a member of the joint committee, I wanted, of course, to be here today and I thank the Chairman for allowing me to speak briefly. I thank Róisín and Amy, Mark and Ollie for attending. It is sad they have to be here. We are all here to make sure, as far as we can, that this does not happen again. I know people will never forget Mark and Mary Kate.

Following on from Deputy Creighton's comments, what, if anything is possible, would it take to bring closure? What would allow Mark and Róisín to say, "We have done our best by Mark and it was not in vain"?

The HIQA report states it cannot confirm services in Portlaoise hospital are safe while the HSE says they are safe. The most qualified people to speak about any hospital are the people who use it. Do the parents opposite believe Portlaoise is safe today?

I have to say to Róisín that it goes without saying that she is not a crazy woman. She is the most reasonable and restrained woman after what she has been through. I imagine others have been through this but did not have the ability or the wherewithal within themselves to do what she did. If she had not had that determination, ability or wherewithal in every manner and respect to pursue this, we still might not know what was going on in the hospital. We thank her for bringing that to our attention.

I know Mark raised some other issues about the whole way they want to shove this into the legal process. That is part of the public service; they send out solicitors' letters to close matters down. That is standard in the public service and a culture which we need to change.

Deputy Billy Kelleher: Mary Kate passed away in May 2013. Mr. Kelly and Ms Delahunt were pursuing their individual case up until the "Prime Time" investigation unit's programme. Were they in contact with other families prior to that? Did they come up against stonewalling too before the broadcasting of the programme?

Mr. Mark Molloy: On Deputy Regina Doherty's question about the meeting in October 2013, it was quite a short meeting. At that stage, it had been 20 months since we had copied the original letter to the director of national quality and patient safety. We had a meeting with him the previous December after meeting his own national incident management team four weeks beforehand.

When we got to this stage, it was 20 months after Mark's death. We had the 43 recommendations and we went to hear how they were going to be implemented. When we were told they were here to listen, we said politely that it was the end of the meeting.

We were given assurances the recommendations would be implemented. It was not until Tony Holohan went in after the "Prime Time" programme that some of the recommendations started to be implemented. We were given that assurance. We were also given an assurance by the director of advocacy that the investigation into non-clinical matters would be progressed and finished in a shorter timeframe. As I said earlier, it still is not complete today. It was quite a short meeting. We had had enough at that stage of lip service.

Deputy Regina Doherty: Earlier, Ms Molloy said that Philip Crowley said to her that she was very good at talking but that he was going to have his say. What was his say?

Chairman: I would prefer if members did not name people.

Deputy Regina Doherty: We all know it is the elephant in the room.

Ms Róisín Molloy: The context was that we were trying to get the investigation completed and also trying to get baby Mark's report. As we had limited input into the final report, we needed to see the draft report to see its contents. We were told we would have to go for a judicial review to get access to a draft report, even though all the staff members would have had access to it prior to its publication.

Praveen Halappanavar then actually got the draft report into his wife, Savita's, death. We told them they had set a precedent so we wanted the draft report. That was the context. These are emails, but we are talking about thousands of hours. Every one of the emails was followed up by 20 telephone calls.

Chairman: By Ms Molloy.

Ms Róisín Molloy: Yes. I never went on the telephone and we never went to a meeting without statistics and having researched every policy and the backgrounds and roles of the people we were meeting. It was very much about feeling completely isolated and that we were up against the system and wondering where we would go if the head of advocacy could not support me. At the end of the conversation I asked him what was his title. He told me that it was head of advocacy and I asked him what it meant. He explained what advocacy was and I said I had never felt so alienated and put down by somebody in that position. It epitomised the wall and the complete disdain with which they had treated us. We were treated with disdain. They hated us.

Mr. Mark Molloy: On Senator John Gilroy's comment about the presentation, it is a fraction. It was worked on from 4 p.m. on Friday when I got home from work until last night in an effort to condense it. Without time constraints, we could be here until tomorrow. We have a huge volume of information. It does not go into the inquest into Mark's death or him being classified incorrectly as stillborn. There are many other elements, but we had to try to condense the presentation today. We wanted to focus on what we had been hearing on the news for the past two weeks, namely, that "this was not escalated to national level" and that "this was not on my watch". This proves that both assertions are incorrect.

Mr. Ollie Kelly: Deputy Billy Kelleher asked me what we knew about the "Prime Time" investigation unit's programme. Mary Kate was born in May and we found out in September through a meeting in Limerick that the consultant in Limerick had made inquiries about the care Amy had received in the Midland Regional Hospital in Portlaoise. The consultant there confirmed that she had looked at the CTG scan and said that if she had seen it, she would have delivered Mary Kate straight away and that there were issues within the CTG. At that stage, we decided that we had to meet the doctors at the Midland Regional Hospital to find out what had gone wrong and why and, like all of the families, to make sure it did not happen again. We got on the telephone to make an appointment and eventually were given an appointment in December. We had to go to the hospital, which was very tough. We wanted to have it done before Christmas and if we wanted to have a meeting, we would have to go to the hospital where it had all gone wrong. We wanted to have it outside the hospital, but if we did not attend the December meeting, we would have had to wait until after Christmas. We were very anxious to have it before Christmas to get it out of the way in order that we could have some sort of normal Christmas. It should have been Mary Kate's first Christmas.

At the meeting we were told that they were very sorry. We were told by the consultant that if she had seen Amy's CTG scan or had been called, she would have delivered her straight away. It had been her day shift and she was probably only around the corner.

Chairman: It is okay; take your time.

Mr. Ollie Kelly: We were also told at the meeting that they had never seen anything like this before and never wanted to see anything like it again. We were told that the nurse and doctor were very sympathetic and very sorry and that if we wanted to, we could meet them to hear their apologies.

A question was asked about reviews. We asked whether a systems analysis, related to severe accidents and deaths, had been carried out and were told that it had. We were also told that it had been completed and that we would have to apply to get it under the freedom of information regime.

On the way home in the car we pulled in to get a bite to eat. We discussed what we would do next. I forgot to mention that we said the doctor had failed to read the CTG scan properly and asked what could and would be done. We were told that they were not in a position to do this, that it was for another forum. The language suggested that we would have to take a legal route to deal with the misreading. We were looking for disciplinary action and for the doctor to be shadowed and to learn from it. On our way home, we decided we would leave it at that. We accepted that the hospital had learnt from it. We had been told it had never happened before and that they never wanted it to happen again. At that stage, we believed that Mary Kate had died for a reason, that her death would make the maternity services in Portlaoise safer. We fully believed that. It is how we grieved as parents, by thinking that her death had been for the

greater good.

Christmas came. We had never told our parents and families about what had happened and the fact that Portlaoise hospital had been to blame. We did not want to put that pressure on them. We wanted to get through Christmas and get back to some sort of a normal life and grieve for our little girl. Then, we saw the advertisements for "Prime Time", and we sat and watched Mark and Róisín Molloy, Shauna Keyes and Natasha Molyneaux talk about what has happened to them. We realised then that we were not the only ones, that Mary Kate, and many other babies, had died in vain and nobody had done anything about it. We were gut-wrenched. The following morning, I got up at 6 a.m. and watched it again on Sky+. We cried through it and we were disgusted at how we had been led to believe that we were the only ones and that it was "just one of those things". At Wednesday's meeting, it was a common theme that all the families had felt it had never happened before and that they were the only ones.

As time went on, we contacted the HSE and said we wanted to see Amy's report and find out the ins and outs of it. Only at that stage, when we requested it, was it posted down to me. In fairness to the man in the HSE who spoke to me, he told me it made for harrowing reading, that he was not happy with it and that he would have a proper system analysis review done. Given that it was a registered letter, I had to go and collect it. Although we had been told it was a system analysis report, it was a desktop report. According to the report, Amy had discharged herself against medical advice. When Amy got home from work, I had to sit down and tell her that according to her file notes she had discharged herself. It was a horrible thing for us, and it remains on her file in Portlaoise hospital. We had to go as far as an inquest to verbally right that wrong and have the doctor add to his deposition an apology for making us believe Amy had discharged herself against medical advice.

We went through the inquest procedure. As Amy said, she had to take the stand to prove her innocence, to prove that she had not walked out on her child. Members asked about the evidence that Mark and Róisín Molloy had gathered together. At that stage, they had given us that information and we knew, and everybody knew, that Mary Kate died due to a lack of interpretation of a CTG reading, and we wanted to bring it to a forum. This is the common theme among all the deaths, and everybody knew about it. The CTG interpretation failure happened because the hospital had failed to roll out or implement anything to improve the standard of care. Mary Kate died because the standard of care was poor in the hospital at that time. It could have been, and should have been, improved. There have been recommendations. Deputy Doherty spoke about them and where they came from. Umpteen recommendations have been made going back years and none of them has been implemented because there is no one there to implement them or to follow up on them to make sure they are done. The HSE is great to say: "We accept these recommendations; we will put something in place." That is all fine for this week and next week but when the pressure comes off - we have a referendum coming up - it takes the foot off the gas. It fails to finish them out. It has finished out nothing. The CMR report has not been finished out.

Getting back to how we felt about all we were told at the December meeting, we asked if it ever happened again and if they had anything to tell us. We found out after meeting Mark and Róisín Molloy that the doctor was at their inquest the week before. That was the time to tell us that they had problems, it was the time for open and honest disclosure, the time to say, "We have errors here, we have made mistakes", and that is the time to implement the recommendations that have been made. I will not go on about it because it is still ongoing. It needs to stops now, it just needs to stop. Enough hurt and enough pain has been caused. There were more than 80

families in Portlaoise last weekend and those were the people who came forward. Members need to put the pressure on to get these recommendations implemented.

Ms Amy Delahunt: With regard to the meeting in Portlaoise last week with all the families, the microphone was passed around for more than five hours and everyone told their story. As has been said, everyone was told: "You were the only one." It was the same doctors' names and midwives' names that were being mentioned again and again. A couple stood up at the other side of the room and they talked about the death of their little baby boy in 2007. They had an inquest into their little baby's death in 2008 and they came out and they had eight recommendations in their report. I was thinking when we had Mary Kate's inquest in December that we came out thinking we had done a good thing, that we had done a service going to the public forum of having an inquest. We had the recommendations and that was her little purpose but to find out there was a family doing the exact same thing in 2008, 2009 and up all along, it just feels at times as if the HSE has one long to-do list and says, "We will do that and we will do that", but nothing ever gets done.

A few of the families mentioned doctors and medical staff having a God-like complex as if they were untouchable. If there is no accountability, it makes the parents and the families feel like the deaths of their babies and their injuries did not matter, that Mary Kate's life did not matter and baby Mark's life did not matter and all the other babies. They did matter and these staff should be held accountable. Until they are held accountable, there will be absolutely no improvement in service.

Ms Sheila O'Connor: It is very hard to follow that. I will let Ms Cathriona Molloy do so.

Ms Cathriona Molloy: Senator Gilroy mentioned the funding issue. We are in the situation we are because we are funded by the HSE and the background was our money came from the old North Eastern Health Board because the people on the health board at the time felt it was important to support advocacy and what we were doing and to try to put it on a proper footing. It started off there and the funding has moved all around the HSE. We are where we are. We never tell anybody that we are not funded by the HSE. Ms O'Connor has a great expression. She says the polluter pays. There has to be support for the damaged people within the system. We are honoured to be funded and to be in the job that we do, and to be able to listen to the stories of Mr. Kelly and Ms Delahunt, Mr. and Mrs. Molloy, Shauna, Katelyn and all the different stories. We are horrified and we feel so sickened in our stomachs from what we are listening to. We have been listening to this for years. We are collecting information and trying to feed it back, but the system is not set up in a way that protects the safety of all individuals. That does not happen. Waiting for reviews takes too long. One must get independent and indemnified doctors. Any external person in a HSE review must have insurance. If one kicks up a big enough fuss and it gets into the media, people from outside the country become involved. I was on the Savita Halappanavar review. I was upset, not because I was on the review, but because I was supporting Róisín and Mark Molloy at the time and they were fighting a battle. Now we have media interest.

The situation in Portiuncula is the same. Someone from outside the country has been brought in to do the review. We are still awaiting the reports for those families that have been affected by what happened at Portlaoise. Seven obstetricians have been on the panel and there are 28 reports. If one works it out, that is four each. Go back to the Neary days. I know that is hard, but he cannot be left out. Ms O'Connor and I told the North Eastern Health Board that people needed independent reports into what happened to them. With the board's assistance, we brought two doctors from England. They saw 64 patients between them in four days. They

produced their reports in less than one month and then an overall report of the care and treatment provided to those women. That was done and dusted. Why are we waiting so long to give people answers? Last Friday, I met a young couple who had had a bad experience in the maternity services. The woman contracted sepsis and became very ill. We sat down and had to try to convince an obstetrician that a review needed to be done.

I could list off countless places where we must give assistance. This is the energy that Patient Focus invests in trying to support patients, telling their stories and getting reviews, but there are obstacles in the way. This is important. Róisín and Mark Molloy are unique in what they have done. It is a credit to them, but I have always told them that it is sad that they must lose so much of their personal lives with their boys and their extended family. I did it and know what it is like to lose all of that. I understand their passion in believing that they must do it. The system should not be set up in such a way that this must happen. There is under-reporting to coroners and under-reporting of serious incidents. People on the ground have a duty. Deputy Mitchell O'Connor stated that people did not go to work to do harm. We know that, in the main, they do not. Neary was a different story. However, we must remember how many people worked with him. They moved on. Some are consultants. There is a particular doctor who is a consultant in a hospital.

Chairman: Please, do not name names.

Ms Cathriona Molloy: Midwives have been affected. Many people are affected by it. It is not about going to work to do harm, but about the harm that occurs and how people can be affected by it institutionally. This is what is important. If there are unsafe practices and deviations from care, they need to be learned about. One must retrain. This is a constant job. Every hospital has a duty. The HSE has its remit, but one cannot take from the institutions and managers their individual responsibility for doing their jobs. Leadership comes from the people on the top right down to the bottom. Good people do good things, but if bad things are done, people get used to them.

Chairman: I thank Ms Molloy.

Mr. Mark Molloy: I will answer Deputy Creighton's question on the HSE director general. The schedule that I set out mentions how, on 26 October 2012, correspondence that we had sent to the Secretary General of the Department of Health was referred to the director general. We have the correspondence between the two on file and how one told the other that he believed the other needed to deal with the situation.

Deputy Lucinda Creighton: Which one is that?

Mr. Mark Molloy: The 26 October 2012 one. After we wrote to the Secretary General, he sent correspondence to the director general stating that this matter was for the latter to handle. Members will also see how, on 25 November 2012, we sent further correspondence to the director general. According to information we received under FOI, notice was issued of a meeting between the director general and head of quality and patient safety, QPS, of the HSE, the agenda item of which was baby Mark's investigation. In regard to who should be accountable, I believe that the Minister and not the head of the HSE needs to order an investigation and that whoever is found to be incapable, incompetent or unwilling to carry out their functions, resulting in catastrophic outcomes for patients, should be moved aside or removed from their position.

Ms Róisín Molloy: In regard to Deputy Fleming's point about what will bring about closure

for us, I do not believe that will ever happen. As in the case of raising children, whom as the saying goes never leave, for us the same applies in this regard. There must be a legal obligation of open disclosure, both for the organisation and the individual. The focus of current policy is on individual doctors and nurses. We believe the organisation as a whole needs to embrace that and to end the culture of blame in terms of who is at fault. There is also need for an audit of where we are at in terms of maternity services in Ireland, to include mandatory reporting of deaths of and injuries to babies.

On the issue of patient advocacy, the voice of patients is a good indicator of how well services are operating. Patients must be listened to and viewed as equal partners. We believe that patients need to be the masters of their own medicine and that when something goes wrong they can speak up and have what they say acknowledged.

Chairman: By way of information, the committee recently completed hearings on the cost of medical indemnity, one of the recommendations of which deals with open disclosure.

Senator Colm Burke: On the point made by Mr. Kelly regarding the lack of sharing of information between hospitals in regard, in particular, to agency and locum staff who make a mistake in one hospital and then move on to another hospital with whom that information is not shared, it is an important that point is highlighted within the HSE.

Mr. Mark Molloy: On the point made by Senator Burke, we made that point to the chief medical officer a couple of weeks ago. As there are particular colleges in England from which the NHS will not recruit but Irish agencies do, we also recommended that such information be shared on a European-wide basis.

Senator John Crown: We should not have any requirement or need for locums. We should have a sufficiently well-staffed service to enable cover when a staff member becomes ill or is otherwise incapacitated. It is wrong that we have locums in the first place. It is a Band-aid over the problem of under-staffing.

Chairman: On behalf of the committee and non-members of the committee I thank Ollie, Amy, Róisín, Mark, Sheila and Cathriona for their presentations. Despite the tragic reasons we are here, it has been a privilege to meet them. I thank them for their presence, advocacy and courage.

Deputy Caoimhghín Ó Caoláin: We should acknowledge what the witnesses have done and applaud them.

Sitting suspended at 2.20 p.m. and resumed at 3 p.m.

The committee met in private session at 3 p.m. and resumed in public session at 3.15 p.m.

HIQA Investigation into Midland Regional Hospital, Portlaoise (Resumed): Health Service Executive

Chairman: I welcome to our second session today the representatives from the HSE, led by the director general, Mr. Tony O'Brien, Ms Laverne McGuinness, deputy director general, Dr. Colm Henry, clinical adviser for HSE acute hospitals, Professor Richard Greene, director of the national perinatal epidemiology centre and professor of clinical obstetrics, Dr. Philip

Crowley, national director for quality improvement for the HSE, Dr. Susan O'Reilly, CEO of the Dublin-Midlands hospitals group, Mr. Liam Woods and Ms Angela Fitzgerald. I thank Mr. Ray Mitchell for co-ordinating on this and thank the representatives for attending.

Our meeting today is a continuation of our examination of the HIQA report and its findings in regard to safety, quality and standards of services provided by the HSE to patients in the Midland Regional Hospital in Portlaoise. This morning, we met parents involved and it was one of the most emotional meetings I have had as Chair of this committee. Again, I wish to thank the parents who attended and presented to the committee this morning.

I welcome our witnesses this afternoon and draw their attention to the fact that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him or her identifiable.

I call the director general of the HSE, Mr. Tony O'Brien, to contribute.

Mr. Tony O'Brien: Thank you. The normal convention is that I would submit a written statement and then proceed to read it out here. I have elected not to do that on this occasion, because I do not think it would be the most appropriate way to proceed, but I do wish to make some remarks.

Any loss of a baby is always a tragedy, and where that is an avoidable loss-----

Chairman: I wish to point out to Mr. O'Brien that the families who were present this morning are now in the Visitors Gallery.

Mr. Tony O'Brien: Thank you. Any loss of a baby is always a tragedy and this is doubly so if the loss is avoidable. It is also true that any indefensible behaviours, lacking in basic human compassion, multiply that tragedy and cause unimaginable trauma and hardship. I want to make it clear that nobody is here today with a view to defending any of that.

As director general, I have made the organisation's and my personal position crystal clear on the central issue of compassion in care. I have communicated to all staff in the organisation that the required standard, particularly when things have gone wrong, is that we treat our patients, our clients and their families as we would wish to be treated ourselves and as we would wish our relatives to be treated. This message has been communicated to leave everyone in our wider health service in no doubt of the expected standard of behaviour.

In other jurisdictions where there have been failings in showing compassion such as in neighbouring countries, one of the approaches has been to seek to reinvigorate the capacity of leaders in the relevant disciplines to reinvigorate compassion in providing care. We will follow that example by inviting the Florence Nightingale Foundation which has been performing this

function recently in the National Health Service in the United Kingdom to provide exactly that kind of enablement training for nursing, midwifery and interdisciplinary leaders throughout the health system and in all settings, not just acute services.

There are also very significant concerns about the way issues of risk were escalated and responded to within the health service. The HSE is instituting a formal disciplinary investigation into the issue of risk escalation and response and the issue of the absence of compassion in providing care. It will utilise external investigators who have never worked in the health service to carry out investigations in accordance with fair procedures and the disciplinary procedure in order that the requirement for accountability can be served.

In addition, there are concerns about governance, particularly in some of the smaller settings and their linkages with larger settings. As a result, we have commissioned Mr. David Flory, CBE, the outgoing chief executive of the Trust Development Authority of the NHS, to begin a process of examining these issues in some of our smaller services, in particular, and especially those involved in maternity services. That process will be extended to all services. This is not just about accountability. It is also about how we ensure these things do not recur and how we ensure services are improved to the greatest extent possible.

As the committee is aware, I was asked by the former Minister for Health, Deputy James Reilly, to be the first and I believe the last director general of the HSE. I took up the role on a designate basis in August 2012. At the time it was made clear to me by the then Minister that one of the reasons he had appointed me was that I had for some time been one of the chief critics of the way in which the HSE had been set up and the way it functioned, which was particularly centralised. It was my view then that the organisation was too big to function in its current construct. My experience of working in BreastCheck and CervicalCheck under the national cancer control programme led me to believe it was necessary to create different levels of governance in order to improve the way the whole system delivered. I, therefore, took the job on the specific basis that I was being asked to lead on that programme. In other words, I would not have taken the job in order to maintain the *status quo* in an organisational sense. In that context, the programme in which we are engaged of creating hospital groups, on the one hand, and community health organisations, on the other, is the central way in which we are improving the health service, not just for now but into the future, in order that decision making can take place, in the hospital sector in particular, within the context of governance constructs of arrangements of hospitals that make both geographical sense and bring management closer to the delivery of care and enable much of the networking and reorganisation of services to take place in a planned and coherent way. Similar issues arise in community health organisations, but I will not dwell on that aspect.

Contrary to what has been reported, the then national director of acute hospitals, Mr. Ian Carter, in response to the "Prime Time" programme on the Midland Regional Hospital in Portlaoise, immediately went to the hospital and engaged in a process which led to the appointment of a specific manager and a director of midwifery for the maternity services and the acceleration of a performance diagnostic. I also accelerated some of the things about which we had previously talked at this committee in terms of changing the structure of quality functions within the organisation and the relationship between these quality functions and the divisions with line responsibility for services. In addition, after difficulties surrounding the competitions to fill the chief executive posts relating to those hospital groups, in the latter part of the second half of last year I took the decision to move the most effective talent we had available in order to ensure that life was breathed into the groups.

In that context, Dr. Susan O'Reilly, who is accompanying us today, was recently appointed as chief executive of the Dublin-Midlands hospitals group, the relevant group in this case. Dr. O'Reilly agreed to move from the national cancer control programme in order to take up her new role. The fact that I asked her to do so and that she accepted is a statement of our commitment to make the Dublin-Midlands hospitals group as effective as it possibly can be in addressing all of the concerns that exist.

As I have stated previously, we accept all of the recommendations contained in the HIQA report. It is true that we have concerns about some of the process issues relating to who did and did not have an opportunity to comment on the report. I will not dwell on that matter now but I will be happy to answer questions in respect of it if members wish me to do so. However, there are some continuing errors of fact, one of which I have referred to, namely, the notion that nobody at national level responded in any way to the concerns that emerged on foot of the "Prime Time" programme. I have explained to the committee what happened there. It is suggested in the report that it was the HSE which took the decision that Portlaoise should remain a model 3 hospital. As members are aware, the Government policy decision in this regard was announced at one of the committee's meetings in 2011.

The HIQA report also lacks any reflection of resource issues. In reference to resource issues I wish to make clear that these do not explain, excuse or minimise the importance of matters such as compassion and care. They do, however, have a significant impact on the way health services are delivered. The HSE is obliged to work within specified resources. During the years in question, those resources were diminishing significantly. I wish to provide the committee with a couple of examples of why resources are key in terms of quality and safety. As discussed last week - I believe it was Senator Crown who raised the matter - and in the context of international comparisons, we should not have 120 obstetricians, we should have 240. Making the shift in this regard would cost €24 million in a full year. Of course, such a shift could not be achieved in a full year. We now need to appoint directors of midwifery. Our decision to appoint one in Portlaoise was somewhat innovative but it has proved successful and is now recommended by HIQA. Appointing directors of midwifery to an additional 14 units would not be without resource implications.

Much is said about the HSE either being or not being a learning organisation. The term "learning" is important but many of the entities which have the characteristics of being learning organisations invest significantly in terms of time and effort in order to learn. If we were, for example, to release all members of our staff for just one day each year in order that they might focus on learning activities in the context of our care service, the cost of replacing them would be €9 million. If we wanted to release them from duties for a week, it would cost €63 million. Staff releases, training, etc., were among the first things that went when the financial emergency occurred. The HSE has not yet recovered to the position whereby it has the financial resources available to allow it to reinstate them. There would also be a significant cost involved if we were to bring all of our emergency departments, EDs, to a point where they would have full 24-7 consultant cover.

While the points I am making are not in any way being put forward as excuses in the context of issues relating to compassion, they are an important part of the overall matrix when it comes to quality and safety within the service. We had a discussion with HIQA about that, mostly because its terms of reference require it, under the legislation, to take into account both Government policy and the resources available to the executive, which it elected not to do.

In terms of the future I am absolutely convinced that the course we set out on two and a half

years ago to create hospital groups, to change the way the organisation was structured and to remove the regional layer is a journey that, when complete, will have an enormous impact on the quality of the services we provide, on the way we relate to our staff and on almost every aspect of the delivery of health care in Ireland. That is a journey that I intend to complete for those reasons.

It is often said, and I agree, that this report is a watershed. I have an additional reason for saying this. It is because it has a huge impact, and will have a huge impact into the future, on the interplay between Government policy and funding and on the role the HSE must play in interpreting those issues when it decides how services will be provided. This is written fairly large in the report and represents a variation on previous practice. Given that the report has been issued, it has a fundamental impact on how the health service will have to operate in the future.

Chairman: As we did this morning, we will take groups of three. I would appreciate it if members could be concise with their questions rather than giving Second Stage speeches. I call Deputy Kelleher.

Deputy Billy Kelleher: How many minutes do we have?

Chairman: Up to ten. Non-spokespeople have up to four minutes.

Deputy Billy Kelleher: We welcome Mr. O'Brien again. We know there are restrictions on what an Oireachtas committee can say and on discussing issues in great detail, which arose as a result of the Abbeylara judgment, so we will keep our comments generic. Mr. O'Brien and his colleagues are the collective leadership of the HSE and have responsibility for the HSE.

In our detailed discussion this morning, Ms Róisín Molloy spoke of her experience and that of her husband. We also heard from Ollie Kelly and Amy Delahunt and from Patient Focus on the issues in Portlaoise. In her closing testimony, Ms Molloy said: "We were treated with disdain. They hated us." It was powerful because she had outlined the efforts she had made as an individual from the day her baby was born in Portlaoise on 24 January 2012, culminating in a continual effort to get to the truth of what happened and to ensure it would not happen to others. We also heard that many people had told Ms Róisín Molloy during her interaction with the HSE that this had not happened before and would not happen again. Unfortunately, just last Wednesday, the Minister heard many testimonies from many people that things did happen before, such as a lack of compassion in dealing with people who had issues relating to their health care and when they made subsequent efforts to find out the truth of what happened. It has been happening for some time, Mr. O'Brien, and it is an issue we would like to be addressed in a meaningful way.

Mr. O'Brien spoke about a watershed moment, and HIQA last week said this was a watershed report. It is a very detailed report and makes for harrowing reading in parts. It is not very complimentary of the HSE in general. Mr. O'Brien said he takes issue with some of the findings in the report but not with the recommendations, which I assume he accepts. I will go through some of the areas referred to in the report. On page five there is reference to weak oversight and inaction. On page eight it states there was "no evidence that the HSE nationally was proactively exercising meaningful oversight of the hospital and the inherent risks there". On page 18 it states there was "an ongoing failure on the part of the HSE to evaluate the services provided at Portlaoise Hospital against the risks and recommendations identified in previous local and national reviews and investigations conducted by the Authority and HSE". It further

states: "Sufficient action was not taken by the HSE at national, regional or local level to address these issues." On page 46 it states: "Whatever the rationale for any decisions underpinning the model of care to be delivered at Portlaoise Hospital, it would be expected that the HSE would ensure that the hospital was safely structured and resourced to provide the care it was delivering." I would appreciate Mr. O'Brien's response to that comment in the report. He made reference to the fact that it was a policy decision that Portlaoise was retained as a model 3 hospital. He said that was a political decision announced here at the health committee. At what stage does policy override patient safety? If a decision is made at policy level for something to be done and the HSE is charged with responsibility for implementing that policy but if patient safety is an issue, at what stage does the HSE say that it cannot deliver on that policy? I would like some clarity on that issue also.

The report states: "In 2013, [HIQA] recommended that the Department of Health and the HSE would work together to conduct a review of the national maternity services and develop and implement a National Maternity Services Strategy." It further states: "At the time of finalising this report 19 months since the Authority published this recommendation, a national maternity strategy has not been developed or significantly progressed. The Authority considers the delay in developing and publishing a national maternity strategy unacceptable." I know that a review is currently being carried out, as announced on foot of the draft report being presented to the Minister.

It seems at every level that the efforts by the families - we must always centre this back on the families - to try to get to the truth of what happened in their circumstances were stonewalled and barriers were put in place. I do not say that lightly; I say that because I genuinely believe the families' testimony to us and that other families I have met and listened to felt that at every level the HSE was very slow in its efforts to come forward with information. We have some testimony from families, particularly from Amy, Ollie, Mark and Róisín, who said they were basically informed that they could get the information through a freedom of information request. We know there is not yet a policy of open disclosure in the HSE services across the country but at the very least one would think there would be an inherent compassion in an organisation like the HSE to help the families get through their grief, but it seems right through all this that the opposite was the case.

I find it hard to accept, having read through the full report, that patient safety was not on the agenda, as stated in the report. Patient safety was almost never on the agenda in terms of discussions at national level even though, by any stretch of the imagination, everybody who was in a senior management position in the HSE would have or should have known at that stage that there were major concerns in Portlaoise hospital and that they were being expressed to senior management at both local, regional and national level. The report by HIQA and the statements by the families indicate there was a very slow response or, one could say, no response in many cases to the alarm bells that were ringing. We talk about a systems failure and the fact that red flags were not being raised but, as I said to Mr. O'Brien last week when we were discussing other issues, alarm bells were sounding off everywhere at every level. The State Claims Agency was writing in this respect, the INMO was lobbying for extra resources and patients who had terrible experiences and tragic outcomes were consistently contacting the HSE but almost to a person they were consistently being denied an opportunity to fully find out what happened. If the families who had tragic experiences in Portlaoise hospital had been embraced by local, regional and senior management, happier outcomes could have come about for those who interacted with the health services at a later stage.

Mr. O'Brien referred to a watershed. In 2008 there was a report on the provision of care of Rebecca O'Malley. Again in 2008, there was a report on the investigation into the provision of health services to Mrs. A by University Hospital Galway. In 2009 there was a report on the investigation into the quality and safety of services in the Mid-Western Regional Hospital, which is known as the Ennis report. In 2010, there was another report on Mallow hospital, referred to in this report as Mallow. In 2012, there was a report on the investigation into the quality, safety and governance of the care provided by Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital, and in 2013, there was a report on the care and treatment provided to the late Savita Halappanavar.

The constant difficulty we have is that these HIQA investigation reports made a number of findings and recommendations for the relevant hospitals, and the Health Service Executive, HSE, nationally, which should have been used by all health care services as a learning tool to inform and improve practice and drive service quality and safety.

Chairman: The Deputy is on eight minutes now.

Deputy Billy Kelleher: We have had six reports to date, and we always believed that the recommendations in those reports were to be implemented across all health service provision in the areas they affected. It is difficult to accept that this is a watershed. It will be a watershed, a defining period, if there is full and prompt action.

I do not want to lay all blame at the door of the HSE. There is a responsibility to ensure that we provide the adequate resources, but at some levels it had nothing to do with resources. Basic humanity and compassion should never be a resource issue. It is about natural courtesy. A willingness to embrace people and help them through their trauma and grief does not cost anything. A phone call or to return a phone call should not cost a lot, as opposed to families waiting weeks to receive phone calls. Having to consistently beg for information is appalling and is something for which no resourcing issue could ever be used as an excuse.

In terms of reporting and the National Perinatal Epidemiology Centre, NPEC, in Cork, it seems to be the case that we still do not have a proper reporting system in place for infant deaths. Why is that the case? We have a number of statutory agencies that report infant mortality and behind the figures nationally we should dig a little deeper to ensure we are not missing some other problems in our health services in general.

Chairman: Deputy, your ten minutes are up.

Deputy Billy Kelleher: In terms of inquests and the HSE, I have spoken to some families who said, and some of the families present stated it also, there was always an encouragement by the HSE to initiate court proceedings and seek compensation. The view that could be drawn is that by doing that, the very minute papers are served on the HSE, any internal investigations are suspended for that duration. Also, if one goes to the steps of the court, very often the HSE will pay out compensation without admission of liability, and therein the issue is parked forever and a day. Should we move swiftly to an open disclosure policy and ensure that the report and its recommendations are implemented quickly?

Finally, does Mr. O'Brien honestly believe that the HSE can implement the recommendations in the report or does he believe that some other outside agency or oversight body should be established to ensure that the HSE can conduct its affairs and bring about an orderly implementation of the recommendations, in view of the fact that many parts of the previous six reports

were ignored?

Deputy Caoimhghín Ó Caoláin: My questions and remarks are directed at Mr. O'Brien. However, I would like it to be noted that they apply to everyone in a senior management position in the HSE and it is a shared and collective responsibility.

To what specific references, in what one is told is a largely unaltered HIQA report on Portlaoise hospital did Mr. O'Brien object? Does he still hold to those objections? He felt strongly enough to issue the threat of legal action on the presentation of the draft report. He is on record as stating here last week, as did the Minister for Health, that he accepts the recommendations contained in the report. However, will Mr. O'Brien refer members to the sections of the report he felt so strongly about that, as I have stated, he issued the threat of legal action to suppress that report? Will Mr. O'Brien also confirm this is not the first time that he or the HSE have endeavoured to suppress the detail in respect of the Portlaoise babies scandal? Is it not the case that Mr. O'Brien or the HSE sought to suppress the "Prime Time" programme broadcast on 31 January 2014? Is it not the case that it was when, as with HIQA, RTE showed stoicism and refused to buckle under threat of legal action to close down the programme and proceeded with it that Mr. O'Brien then withdrew his threat? Was it not on the back of that stance by RTE, in light of the fact that the programme was going to proceed, that the HSE issued an apology to the parents concerned just before the broadcasting of the programme?

Of the evidence presented to the joint committee this morning, one of the areas of most concern for me was that it was reported to members that two senior post-holders of the HSE met Mark and Róisín Molloy in October 2013. The proposal was to discuss the implementation of the 43 recommendations in the report concerning the tragic loss of their young son, Mark. However, members were advised they were told that the two senior figures were only there to listen, which does not equate in my mind or in theirs or in that of any other member of the joint committee who heard their contribution this morning with discussion in any shape or form. I ask Mr. O'Brien to comment on that.

Deputy Mary Mitchell O'Connor took the Chair.

Deputy Caoimhghín Ó Caoláin: Let us look at what the HSE has to say on its own website about itself and the commitment to what one can expect from the HSE. Under the statement "What you can expect" from the HSE regarding dignity and respect, it states, "We treat people with dignity, respect and compassion". I do not believe any of those could be ticked after listening to the case presented this morning. Under safe and effective services, the HSE claims "We provide services ... in a safe environment, delivered by [competent, skilled and] trusted professionals". It is the case across the HSE and across all the health delivery systems that indeed we have highly competent, skilled and trusted professionals and thank God for it. Members commend them, each and every one, but there are issues here and there are those who clearly are falling down seriously in their responsibility to meet and address issues of what should be shared concern. Under communication and information, the website states, "We listen carefully" while under participation, it states, "We involve people and their families and carers in shared decision making". I have only cited a number of the eight areas, the eighth of which is accountability, where it states, "We welcome your complaints and feedback about care and services". There is no evidence of any welcoming of the feedback on the care and services in these instances. As for complaints, I do not believe the parents in the circumstances in question were at all met as the HSE states is its policy.

On RTE radio on Sunday, the Minister for Health, Deputy Leo Varadkar, stated parents of

babies who died at Portlaoise hospital were "lied to" by people who have been accused of covering up what happened to them. How would Mr. O'Brien respond to the Minister's charge?

For balance, I wish to say I welcomed the circulation last week of Mr. O'Brien's letter of February 2014. I commend him on the action he took and the thrust of the correspondence. It was reported on at the time but I had not seen sight of the construction of the letter. I welcome it very much. Its thrust is absolutely on the button. However, is it not now time to reissue such a communication to all health service staff given that it is evident that a number of staff across the health services are not reaching the high standards Mr. O'Brien himself insisted upon in the communication of 6 February of last year? In light of the evidence of a failure to adhere to the high standards Mr. O'Brien suggests should be the norm across the health services, should such a communication not be accompanied by evidence of enforcement? Are we not now at that point? Will Mr. O'Brien respond accordingly? I fully accept and do not doubt for a moment that the communication reflects Mr. O'Brien's genuine wish for the health services.

There is a significant time lapse before the appointment of an investigation team, reviewer or review panel and this is feeding into a serious lack of confidence. I am speaking quite specifically about maternity services and maternity-related reviews and investigations. The appointment is taking far too much time. Will Mr. O'Brien intervene to insist on these reviews and investigations being conducted not on a part-time basis but on a full-time basis to ensure the earliest possible publication of the findings and recommendations?

With regard to a number of hospitals, specifically Cavan General Hospital, it is a fact 30 months after the tragic death of baby Jamie in November 2012 that we have yet to see a single line published. That is wholly unacceptable to the baby's family and also the wider dependent community. In paying tribute to the overwhelming number of excellent staff who work in the unit in question, I believe it is absolutely unacceptable to them also.

Acting Chairman (Deputy Mary Mitchell O'Connor): I call Deputy Healy.

Deputy Seamus Healy: I am ceding time to Senator Crown.

Deputy Jerry Buttimer resumed the Chair.

Senator John Crown: Deputy Healy has kindly yielded. I am very sorry I was not here for Mr. O'Brien's presentation. This is not a day I normally have blocked off for Seanad activities. I am afraid that there are certain parts of the schedule that have become a little inflexible. I thank Deputy Healy for giving his time to me. If any of my ten minutes are left over, I would like to give them back to him.

The reality is that Mr. O'Brien has been given a certain job and framework within which to work. People who study management systems and health systems would see there is a certain internal logic to the way in which the whole system has reacted. It is not one we would necessarily approve of but there is a certain internal logic to the way certain management responds when certain issues arise.

I will now ask a few brief questions about the response to individuals who had raised issues of concern about the quality of care their families had received and also through their representatives, professionals, the media and public representatives. How much of the response does Mr. O'Brien believe has been formulated directly by those with line responsibility and how much has been formulated by people who are professionals in public relations, stakeholder engagement and the law?

I ask Mr. O'Brien to give a heartfelt answer to another question which is not redolent of judgmentalism. That is because I think certain organisations behave in certain ways because they were set up to behave in these ways. Does Mr. O'Brien think there is a sense that the HSE adopts a reflexly adversarial and defensive posture in the face of quality issues brought to its attention by its clients, by patients? Does he think there is a tendency to suddenly see people who come to raise an issue as somehow being disenfranchised as clients, customers or patients and as something else, as an external threatening force that is now looking at it from the outside?

I suspect that Mr. O'Brien is being put on the grill a little bit, but I want to get his opinion. Does he think we have an abnormal health system? Does he think the health system is, by international standards of comparison, very odd in terms of staffing ratios, the extraordinary internationally unprecedented reliance placed on the efforts of trainee doctors who are still undergoing senior professional and sometimes very junior professional training as actual service providers? In some of the cases about which we have heard in the past few days it is quite obvious that this is the case, that people who were clearly not fully trained and inexperienced were put in the position of having inappropriate levels of responsibility thrust on them.

This is a harder question. We have fought long and hard for systems to deal with disciplinary infractions by doctors, nurses and various other professionals. We have regulatory bodies, some of which the professionals sometimes reckon can act with a degree of heavy handedness. In many cases, they arose in response to prior deficiencies where there had not been sufficiently vigilant regulatory agencies monitoring the activities of professionals. We have them now. The truth is there really should not be any reason a patient, a relative, a bereaved person or anybody who believes the actions of a doctor or a nurse have fallen short of acceptable standards should not have some form of redress involving an appeal to a regulatory body. Does Mr. O'Brien think we have this on the administrative side of the health service because I do not?

The tragic hysterectomy case in Drogheda arose again today. Trust me, I am not doing a collective professional Pontius Pilate in trying to stand up for doctors. There is no doubt that an awful series of fundamentally inexcusable, unforgivable and horrific malpractices which caused terrible life destruction to a lot of people occurred there. I kept looking at it, however, and was thinking about it from the outside saying, what kind of health system lets somebody, operate effectively single-handedly for so long without backup, without a sufficient number of colleagues in place to provide for a degree of peer review, without an intensive care unit, without an adequate number of anaesthesiologists, without the same staff being there on an ongoing basis to see trends emerging, or without a blood bank? In that way, somebody with a severe deficiency and shortage of skills would have been picked out.

It always struck me that there were individuals who had been warned about that system and let it continue. After 22 years the word I use to describe my reaction to try to reform the health service is "despondency". I do not think it is fixable. I was very taken and upset this morning by what I had read in the paper. It was a report that serious, expert, professional notification had been made by senior obstetricians that there were problems. It was not from people who could be dismissed as perhaps inexpert. I would not be the one to accuse them of this, but I am sure it is the kind of charge that is levelled by people who are too emotionally involved. However, serious, dispassionate, sober professionals looked at it and said, "There is a problem here," and it looks like it was ignored.

There has been a great deal of discussion here of the issue of individual versus collective responsibility. We are not supposed to name names, but I will name a few: Howlin, Noonan, Martin-----

Chairman: I am sorry, Senator, but with respect, I am Chairman of the joint committee.

Senator John Crown: I acknowledge that.

Chairman: I will defend-----

Senator John Crown: Do you deny that these men and women were Minister for Health?

Chairman: The Senator was late for the meeting and not here for the private session.

Senator John Crown: *Mea culpa.*

Chairman: Let me make a comment in the interests of balance and fairness. I want to protect all of us in the room and the Senator was missing for the start of the private session. I ask him not to name people who are not here.

Senator John Crown: I will not. I withdraw the names, but I believe that, collectively, all Ministers for Health in modern times in the State were asleep at the wheel and allowed this to happen. That is the way the system has evolved; they are the people we picked to do it and it is there responsibility rests. It is also from there that reform will come. I am hopeful the new Minister will actually acknowledge, as he seems to have done, that things are really abnormal and need to be fixed. They have needed to be fixed for a very long time.

Chairman: In the interests of protecting all of us, we had a private session and were given legal advice on naming people. This is not a court of law. As Deputy Billy Kelleher said, the Abbeylara judgment confines us in what we can and cannot do as a committee. I want to protect everybody involved in the hearings today and last week. That is why I am being careful about what members can and cannot do.

Senator John Crown: I would gladly give the opportunity to all former Ministers for Health to say the problems in the health system had nothing to do with them. I would be delighted to hear them say this.

Chairman: I have no issue with the Senator naming Members of the Houses, but it is former Members or those who are not here or officials to whom I refer.

Mr. Tony O'Brien: In order that the question about the NPEC does not get lost in my response I will start by asking Professor Greene, the director of the NPEC, to respond. I also remind members that when the Chief Medical Officer was here last week, he made reference to certain actions the Department of Health was taking with the Department of Social Protection on some aspects of how neonatal and perinatal deaths were recorded.

Professor Richard Greene: The question was why we did not have a proper reporting system. Deputy Billy Kelleher asked it. There are a number of things going on and sometimes people get mixed up about exactly what is happening. The majority of our statistics with respect to perinatal mortality, that is, babies who die during pregnancy or in the first week after pregnancy, are provided officially through the birth registration form which goes to the CSO and what was the ESRI but is now incorporated into the hospital pricing office in the HSE. That is where the information comes from. The national perinatal centre was set up to look at perinatal health. It collects data directly from hospitals on a voluntary basis. The information collected is not just on babies but also mothers. The centre is also involved in maternal death inquiries. There are always issues in respect of this kind of information. While I know that it is not kosher today, it absolutely gets to the point to look at maternal deaths. A maternal death

inquiry is a confidential evidence-based inquiry which adopts what is considered internationally to be the appropriate approach. It is based on the English system. We pick up about two and a half to three times the number of maternal deaths found in the official statistics. There are reasons for this which we have pointed out in many of the reports in the past few years. In fact, we have started to work with the CSO on that issue in order that we can both ensure we are getting the appropriate numbers.

The centre takes data on babies who, sadly, die. As a practising obstetrician, I note that this is an area that is extraordinarily difficult in terms of management and very pressing and devastating for patients with life-long effects. It also has an effect on us as staff. It is an area that is extraordinarily sad and difficult, but it is also an extraordinary area in which to practise as we can have a great effect in helping people through it. When a baby dies in a hospital, the report on the event is a completed audit form. It is not just that a baby died but it takes in information about the pregnancy, the mother, time of death and any clinical information on the baby that is available. This allows us to look at perinatal death and the causes.

Every one of these babies and their families are extraordinarily important. It is also important to remember, however, that annually in this country about 450 babies die. Up to 150 of those are associated with congenital anomalies which puts them at a slightly higher risk. The others are associated with many causes, some of which are difficult to detect. One we are now beginning to learn about is that some babies do not grow as well in the womb which accounts for 50% of the normally formed babies who die during pregnancy or around the time of delivery.

We are interested in more than just numbers. We go behind the numbers to find out what happened. One issue associated with one of the reports on Portlaoise was over numbers. There was an issue between the numbers from the CSO, the ESRI and ours. Statistically, it depends on what definition one takes. This country's perinatal mortality rate for all babies over 500g is just over six per 1,000. That equates to a not insignificant number in total. It is as good as, or better, than most of our European counterparts and internationally significantly better than some very wealthy countries. Norway and other Scandinavian countries are held up as being so much better than us. They quote a figure of about two per 1,000 which makes us look bad. However, if we take the same definition they use, then our rate comes in at 2.1 per 1,000.

We are good at what we do but we still have a significant number of families affected every year by perinatal loss. Sometimes, unfortunately, families and potential parents are not aware of that. I do not believe we will ever completely stop this but we can reduce the numbers. To do that requires investment by us academically and by the health services. That requires society to decide that this is important.

The comparison I drew last week, which may be interesting to the committee, concerned road traffic accidents. There is rarely a day when one turns on the radio that one will not hear about road traffic accidents from the Road Safety Authority, and appropriately so. There are 160 to 180 deaths per year on the roads. Up to 450 babies die. We need to have an understanding of exactly what is going on.

The reporting system we have is adequate. Where it falls down is sometimes around definitions. It could be assisted by having a full-time committed officer to collect and produce this information annually. Like many tasks in our health service, many of us are doing this in addition to our full-time jobs.

Mr. Tony O'Brien: Senator Crown asked some interesting and wide-ranging questions. He asked if I consider that the nature of the health service is odd by international standards. The objective answer to that question has to be "Yes." The mixed model we have in this country - the blend between public and private - is comparable only to that in post-Saddam Iraq in terms of international comparators. That is one thing that is odd.

The diffuse nature of health service delivery in Ireland, particularly acute care, the number of locations and so on-----

Chairman: There is a sense of *déjà vu* in that Mr. O'Brien is hard to hear in the Visitors Gallery.

Mr. Tony O'Brien: My apologies. I will take another drink of water. I will begin again.

In response to Senator Crown's question I was referring to the nature of the health system compared to international standards. There are certain characteristics that are atypical. The particular mix we have between public and private provision is probably comparable to that in post-Saddam Iraq. There are not too many comparators with the same blend. The number of acute locations here is rather large by comparison with that in other developed countries with the same population density and overall population size. The number of smaller units here is, therefore, greater than that in comparators, while our largest units are not as big as they often would be in many locations. There is an over-dependence on agency and locum doctors and doctors in training. We have previously talked about this issue at this committee. There are a number of related factors. Some locations experience particular challenges in that regard because, without wishing to be pejorative, they are regarded by prospective job applicants as geographically peripheral, which simply means that they are not located near large urban centres, large universities and so on, even though they may be near very nice parts of the country. Letterkenny is often used as an example, as is the Midlands Regional Hospital.

Senator John Crown asked a question about the nature of the public response. By and large, the vast majority of instances where it is necessary to issue a public comment on issues related to patient care are handled at local level. Where there are significant issues that have a national focus, by and large, the people in charge of services, either regionally or nationally, handle them. Increasingly, community health care organisation, CHO, and hospital group chiefs shape the nature of the message. They will assess the circumstances and what it is acceptable to say without breaching confidentiality and so on and seek to communicate in a way that is faithful to the circumstance. On occasion, that does mean that it is necessary to have some legal input, particularly if there is likely to be a follow-on process that we do not wish to prejudice. If it is a matter that is likely to become an issue for the State Claims Agency, in other words, a legal claim against the State, we have an obligation to liaise with it. By and large, the HSE is not an organisation that has recourse to external public relations expertise. That would happen very rarely. I suspect we are one of the smallest users of external public relations advice in the State sector. I think that is what the Senator is asking me about in respect of external force.

In respect of disciplinary infractions, there is an important discourse about the nature of regulated versus unregulated professions, not just here but also in other jurisdictions. Administrators or managers are not members of professionally regulated professions, which I think is unfortunate. It devalues these professions and is one of the reasons, at a time when training for managers was eliminated from budgets, continuous professional development funding remained available for the regulated professions because it was a statutory requirement. That meant that people did not receive development training at a personal or professional level to

enable them to deal with some of the challenges about which we are talking. It also meant that, as people came into these posts as others vacated them, they were not given access to the professional development training one would have wanted them to have. I believe the contribution administrative personnel make to health service delivery is sufficiently important to deserve that protection and regulation. That said, the experience of other jurisdictions is that while professional regulation and licensing are important, they can never be substitutes for employer based disciplinary processes. All members of staff in all parts of the health service are subject to the disciplinary code, irrespective of whether they are in a regulated profession. That is as it should be.

In regard to the report in today's *The Irish Times*, members may not be aware that a small amendment was made to the online version of that article. The document at the centre of the report, which I have read, was a follow-up letter to the Minister of the time sent one day after a meeting had taken place with that Minister. The letter made reference to costed ideas prepared in response to concerns about services in the Coombe, Mullingar and Portlaoise. The meeting was part of an overall service planning process involving clinical programmes in respect of which the HSE applied for €22 million in development funding in 2011. On reading the 2012 service plan, I do not see any provision for that investment, which I interpret as meaning the resources available were not sufficient to enable those programmes to proceed. I was not involved in the service planning process at the time, however. The report in *The Irish Times* states that I had been involved in that discussion in the capacity of national director of clinical strategy and programmes. That post was held by a different individual, however. The authors of the letter, in expressing to the Minister how they would like to proceed, mentioned a number of people, including me, as people they would like to work with in implementing the proposed measures. It is true that the letter referenced in the newspaper exists, and I have a copy of it.

I have no knowledge of any threats or legal discussions of any kind relating to the "Prime Time" programme. I asked a colleague to investigate whether anybody else had such knowledge but according to the note that I have received nobody on my team has any knowledge. I am aware that members of the HSE participated in the programme, both in the pre-filmed package and in other ways. It comes as news to me that there was any suggestion of an attempt to interfere with the programme, other than the normal process of providing information, asking questions and agreeing who should take part in interviews.

Chairman: Was there a threat of legal action against "Prime Time"?

Mr. Tony O'Brien: I am absolutely certain that there was no such threat. The only people who would have known about a threat, had it been made, have advised me that they have no knowledge of one. I would expect to have been made aware of a threat.

Chairman: Was the HSE fully co-operative with the "Prime Time" programme?

Mr. Tony O'Brien: The HSE fully participated. As the Chairman will be aware, in the course of any engagement with the media there is often a discussion about how things should proceed, and there may be a difference of views regarding the level of co-operation. I do not know the details about whether "Prime Time" wanted something that it did not get but it certainly received opportunities to film interviews with the people it requested. I know this from having watched the programme and being aware of some of those interviews taking place.

In regard to HIQA, I received a copy of the first draft of the report with a request that I act in a representative capacity to provide feedback on it. My first question was about what that

meant and my second question was on whose behalf I would be responding, in other words, who else had been provided with copies. On reading the report and seeing to whom it might apply, who participated and who, in the ordinary course, I would have expected to be given an opportunity to respond to HIQA as part of its validation process, I became concerned when I discovered that nobody who ever occupied the post of national director of acute hospitals had received even one sentence. I discovered that the then national director of quality and safety had received one sentence, the then deputy director general of the HSE had received one paragraph, and that no nurse or midwife in Portlaoise had received anything at all.

Chairman: Does Mr. O'Brien mean they received one sentence or one paragraph pertaining to themselves?

Mr. Tony O'Brien: I mean from the whole report. The draft comprised only approximately 106 pages, given that it did not include the appendices, recommendations or executive summary. In the ordinary course, anybody compiling a report would seek to go back with a draft to people who had been interviewed or who had been involved in matters to which it related. Some individuals received a sentence, three lines or a paragraph, and others received nothing. Based on communications from staff elsewhere in the system, a number of nurses, midwives and other medical personnel had taken part in workshops, interviews and so on, but had received no part of the document to review, despite having requested it. This was my first area of concern.

I ended up writing to various HIQA officials on five occasions seeking some basic information on exactly what was required of me and asking who else had been provided with sections so that I did not need to go through the process. There were issues that did not seem to have an evidence base and for which I asked to see the evidence base. These letters have been published and there is no mystery about them. The central issue was information and a meeting for the purpose of clarifying what was requested of me. If this were a report by any other regulator, such as the Mental Health Commission, an Coimisinéir Teanga or the Comptroller and Auditor General, these matters would not have been considered problematic. Such meetings and additional information would have been provided as part of the normal course.

Given that this particular regulator refused to engage in any way whatsoever, I indicated that I would have to consider seeking intervention, not to prevent the conclusion of the report but to enable me to do what I was being asked to do, namely to make a submission in a representative capacity on behalf of a wide range of people who were not being given the opportunity. I wrote to HIQA to indicate that if I could not get progress, a judicial review would be under consideration. I simultaneously wrote to the Department of Health asking it to intervene, which it did. As a result, we had a meeting at which additional information was provided, the timetable for the provision of a response was agreed, which needed to be extended due to the amount of time that had elapsed, and we made the submission.

Regarding the changes that were made, I am happy to indicate the matters that were not features of the report but which now are. One of these is the recognition that the national maternity strategy which, as per the Chief Medical Officer's report, was to be published by December 2014, was a matter within the determination of the Department of Health rather than the HSE. In the initial draft there was a critical line that said the HSE was at fault for not having published a White Paper. As members will be aware, a body such as the HSE has no role in the publication of a White Paper.

Absent from the report was recognition of the publication of a number of national guidelines

by the national clinical effectiveness committee and the HSE's clinical programmes including the Irish maternity early warning score, I-MEWS, Communication (Clinical Handover) in Maternity Services, Sepsis Management, The Management of Second Trimester Miscarriage, Guidelines for the Critically Ill Woman in Obstetrics, Resuscitation for the Pregnant Woman, The Diagnosis and Management of Ectopic Pregnancy, and Bacterial Infections Specific to Pregnancy. Also absent was acknowledgement that all hospital were implementing the national early warning score, NEWS, and I-MEWS and that, on average, between 70% and 90% of staff had received full training on their use. The report now acknowledges that significant progress has been made on the implementation of recommendations from the Chief Medical Officer's report relating to the reporting and management of serious untoward incidents, also known as serious reportable events. These include setting up a serious reportable event governance group chaired by the then HSE director of quality and patient safety; publishing a safety incident management policy, which sets out the HSE's policy for managing safety incidents; publishing a list of serious reportable events and an implementation guidance document; issuing a directive to all providers to require them to notify serous reportable events to the national director responsible for their services; and educating staff and training them in respect of safety incident management. The authority also confirmed that the HSE actively progressed the implementation of recommendations made in the Ennis and Mallow reports in small hospitals.

The authority recognised that it was not the HSE that determined the services to be supplied by any hospital but that it was a matter of Government policy. That is stated on page 46. The authority also amended some of its findings entirely and others significantly owing to various more minor issues.

Are there outstanding concerns? I have referenced the fact that a reader of the report and the media reached the conclusion based on the report that nobody in seniority had responded to the "Prime Time" programme by going to Portlaoise or taking any step. In my opening statement I covered the fact that the then national director had spent considerable time in and that the regional director of performance integration effectively had taken over the hospital on a direct basis pending the appointment of the various other post holders I mentioned in my statement. It would be reasonable for people to look at us completely sideways and aghast if they believed nobody at national level had intervened, but it is completely untrue.

Deputy Billy Kelleher has made reference to the other suggestion about which I have particular concern in this regard, that is, that the issue of patient quality and safety more generally is not on the agenda at senior levels of the HSE. We provided for them a detailed submission which comprehensively refuted that suggestion. As members will be aware, in 2013, with effect from 27 July, the board of the HSE was abolished and replaced by a directorate. To be a member of the directorate, one must first be a national director of the HSE. It is an unusual and transitional governance arrangement, but the effect is that the directorate is a subset of a wider leadership team. The reserved functions of the directorate are prescribed in legislation. The directorate meets to perform these reserved functions. It also meets collectively as part of the leadership team with all of the other relevant national directors. At the time, the director of quality and safety was not a member of the directorate, while other key people whom one would want for any discussion such as the national director of human resources and so on were not members of the directorate. The directorate chose, therefore, to transact the bulk of its business, that is, its non-reserved business, as a matter of generality as part of the leadership team. The agendas for that team include quality and patient safety and they were supplied to HIQA.

Chairman: In fairness, I refer to chapter 3, page 5, of HIQA's report. I do not want to take

issue with Mr. O'Brien or be alarmist, but he used the word "aghast". I am sure he has met the families.

Mr. Tony O'Brien: Yes, I have met some of them.

Chairman: One could not but be aghast at the testimony they gave us. As Chairman of the committee, someone who is fair and balanced, as Mr. O'Brien will be aware, what upset me, apart from the stories of the families, was that two organisations of the State - I said this to Mr. O'Brien at last Thursday's meeting - were fighting in public about an issue that was about the parents and their children who had died and their families, in particular. It should not have been in the public domain. Second, why are we worrying about reserved and non-reserved functions when the reality is that patient safety is of paramount importance to all of us? I appreciate that Mr. O'Brien has a job to do, as I do. What jumps out at me in HIQA's report is that it is stated in chapter 3, on page 5, that the safety culture was missing.

Mr. Tony O'Brien: I am responding directly to a question asked of me by Deputy Caoimhghín Ó Caoláin. None of my response is intended, as I said in my opening remarks, to take in any way from the serious failures.

Chairman: No, I accept that, but in terms of the bigger picture, HIQA and the HSE were involved in a spat, which was unnecessary. It looked bad and the ordinary person at home watching the news at night was horrified by what was going on.

Mr. Tony O'Brien: I agree and it should never have been put in the public domain. Unfortunately somebody chose to do so. Deputy Caoimhghín Ó Caoláin asked me specifically what changes were made and where my concerns were. It is in that context that I have shared that information.

I will just refer to my notes.

Deputy Caoimhghín Ó Caoláin: Will Mr. O'Brien deal with the other questions?

Chairman: That is okay.

Mr. Tony O'Brien: The Deputy asked me if I would reissue the communication and I certainly intend to, but it will be in the context of the Florence Nightingale Foundation initiative around reinvigorating leadership for compassion throughout the system which I referred to in my opening remarks. I have already said there is to be a specific disciplinary investigation into failings of compassion, which brings the accountability balance to that communication. So around it, communication will follow.

The Deputy asked in particular about the length of time investigations can take. He made reference in particular to one in Cavan. I will ask Dr. Crowley to comment on that.

Dr. Philip Crowley: I would like to open up by initially apologising to the families - the families present and the families not present - who suffered harm in Portlaoise hospital. I was personally very distressed and sad at the testimonies they have given in various settings, including here today, not only about the failures in care, but clearly fundamentally about the lack of compassion, the poor response to the adverse situation of the death of a baby and people covering things up, hiding for whatever reason.

I have practised for 30 years as a family doctor. I have worked in Central America, in the NHS and here, always trying to work with patient groups to ensure that their voices are heard

and that we are responsive to what people who use our services have to say. I have worked all through that period of time to try to improve services for patients and service users. One can only be deeply upset when care breaks down in this way and particularly care in its fundamental sense - in compassion.

Some of the questions relate to that sense of upset. One question from Deputy Kelleher related to open disclosure. We have developed a policy on open disclosure, as he is probably aware. We have an unprecedented implementation programme around it because we understand from the testimonies of the families here today and from other instances of harm to people that the harm is so compounded by how people react after the event that we know we do not have a culture of open disclosure in our health service.

That is why we carefully developed our policy. I commend it to the committee; it is available on our website. It is a very clear policy. It gives very clear guidance to staff on how to behave, how to respond, how to react immediately. We have run 150 workshops around the country to try to train people in truly adopting this approach, which I recognise represents a culture shift in our health service.

Chairman: What is the timeframe?

Dr. Philip Crowley: We have been training people over the past six to eight months.

To really change the culture to one of open disclosure, we recognise the need to carry out a phenomenal effort in training people. Two people were involved in that - that is the number of people implementing the policy. We are now training trainers to see if we can drive it home, follow it up and ensure it truly becomes embedded. Any investigation from now on and any assessment of how people are dealt with will be done in the light of whether the open disclosure policy, which is clearly communicated to everybody, was properly followed.

Maybe I should come to the investigations now. The time lapse in investigations is another thing that impedes anybody achieving any sense of answers or closure. Historically our investigations have taken too long. There are a number of reasons for this. One would be the difficulty in accessing experts, particularly in the area of maternity. We have heard of the shortages we have in the maternity services. We have had a significant number of demands to seek expertise to facilitate comprehensive investigations and that has caused delays.

Chairman: Was that the case in this instance?

Dr. Philip Crowley: That is the case in almost all of the delays. Another issue in regard to the delays - the Deputy raised it - is the availability of trained investigators. What the Deputy proposed was to have full-time investigators. That would be one approach. However, we do not know where an incident will occur and we wish to have people trained across the entire health system. We have trained in the region of 800 people - 400 managers and 400 staff - to understand how to investigate something properly. In 2014, we instituted a new policy that was strongly influenced by my interactions with one of the families present and others. It puts a clear timeline on investigations. They should be completed within four months. This may seem like a long time, but it is a challenging timeline because we must source investigators and experts and ensure that due process is adhered to. This work often delays investigations.

Chairman: I wish to ask about that. As part of the - I hate using the word "testimony" because we are talking about parents - presentations to us this morning, I counted nearly 33 exchanges or interactions between the HSE and the families. In some cases, there was a 20-week

delay without a hearing. That is not down to starting an investigation or being unable to source people. That is a lack of courtesy and engagement on one level.

Dr. Philip Crowley: Yes, that is exactly how that sounds. A lack of courtesy. Investigators might not have been identifiable in the local service, but they should be now, having trained 800 people. I hope that the situation will improve, that others do not have the same experience, that people get answers more quickly and that we implement findings more quickly.

Deputy Kelleher made a suggestion about the suspension of internal investigations where a legal process was under way. It is fair to say that there was a time when some legal practitioners tried to deter local investigations when cases were being taken. We raised this matter with the State Claims Agency, which agreed that it should not be the case. I would hate to think that, at this stage, any internal investigation would be suspended because there was a legal action. We have an agreement that this will not be the case, and it is not the case.

Those are the issues mainly relating to me that have been raised so far.

Mr. Tony O'Brien: I will ask Dr. O'Reilly to comment on some of the cultural changes in Portlaoise.

Dr. Susan O'Reilly: I am the new CEO of a very new hospital group, the Dublin midlands hospital group. I was appointed in November 2014. The HIQA review of the hospital concluded in mid-October 2014, so I arrived after that. Subsequently, I met HIQA to brief it on governance changes in particular. I recruited my small management team. We are a small, focused group. Its members came on board in March and April. We lead the development and integration of clinical networks across seven hospitals, those being, St. James's, Tallaght, the Coombe, the St. Luke's radiation oncology network and the three midlands hospitals of Naas, Portlaoise and Tullamore.

One of my first actions after arriving was to assess the situation based on some of the feedback from a variety of reports, for example, from the HSE and the Chief Medical Officer, and on listening to and learning from Dr. Colm Henry, clinical adviser in the national clinical programme, and five of his national clinical leads for acute services. Dr. Henry may comment on that process in due course.

My first change was to clear up clinical governance within the midlands hospitals, particularly Portlaoise, so that there was no risk whatsoever of any physician being confused about to whom he or she reported. In January, my next act was to appoint a new management structure for Portlaoise and to mimic it across the other midlands hospitals. This change led to having a general management level individual who was the lead for all operations in the hospital, with clinical leads reporting to that person for operations and the professional leads - nursing and clinical director - reporting to my group's individuals in those roles who were their professional practice and strategy advisers. Operations remain the responsibility of the hospital, with which we have maintained and developed a close working relationship.

While we are dealing with the topic of maternity services, I will be more than happy to address other areas in due course.

In respect of maternity services, even before my appointment, there had been substantial change, some of which was outlined by Mr. O'Brien. The appointments of a general manager and a director of midwifery have been enormously successful in beginning the process of changing the culture within the hospital. Cultural change takes time to develop. Staff must

feel supported. A balance must be struck between identifying staff who are significantly and consistently under-performing and who should, perhaps, undergo a fitness to practise or disciplinary process and those staff who may have made a clinical judgment call that in retrospect was not right.

The families who presented to the committee have suffered terrible losses and rightly complained about how they were treated. Often, clinical staff, in particular nursing, midwifery and allied health staff, are afraid to be open because they are afraid of the shame and the blame. It is our job to balance ensuring appropriate discipline for under-performance with appropriate support and open disclosure. These two elements can sometimes counter-balance each other and it takes a while for that culture to evolve. The new director of midwifery, the new clinical lead appointed last year prior to my appointment and the new manager began that change. We are investing in quality and safety complaints management and elements of patient engagement. To date, 16 additional permanent midwifery staff have been appointed, bringing total staff numbers to 72. Another obstetrician has also been recruited, bringing the total number of obstetric staff to four. More particularly, the memorandum of understanding with the board of the Coombe hospital, the infant and maternity hospital, was signed by me and the board chairperson in March. The process of the Coombe hospital taking over the governance and management of a Coombe hospital on two sites, in Portlaoise and the Coombe, is under way.

A director of clinical integration from the Coombe hospital went on-site over one month ago. The role of the director of clinical integration who is a senior obstetrician is to integrate and standardise clinical pathways and policies across the groups. In the interim, there has been progressive and completed work on ensuring appropriate training for midwives in CTG, cardiac monitoring for the foetus-baby during pregnancy and delivery. There has been consistent development and implementation of policies for the safe use of the drug oxytocin and considerable investment in the restructuring of maternity services in that there are now shift leads to whom midwives delivering babies can go, as well as the medical staff. We also have a bereavement support midwife, breast-feeding support, midwifery education support and a number of other structural changes that give confidence to midwives who are in the field delivering babies and working with the medical staff that they have a structure to support them in their education, development and training.

There have been substantial improvements to date at Portlaoise hospital. Although born out of tragedy in terms of the Chief Medical Officer's report and the "Prime Time" programme, we have landed in a good place. We must thank the families for their pursuit of and engagement with excellence. We are achieving consistent and safe services today which will continue to get better as we move towards the new networked model of the Coombe hospital on two sites.

Mr. Tony O'Brien: I must apologise to Deputies Billy Kelleher and Caoimhghín Ó Caoláin and the Chairman in that the answer to the question of whether patient safety was on the agenda was in response to Deputy Billy Kelleher's question. I was slightly confused; my apologies.

On the matter raised this morning with the committee by, I think, Mr. and Mrs Molloy and about officials saying, "We are only here to listen," the transcript of this morning's meeting will be examined in the context of the investigative process to which I referred.

Chairman: They were also told, "You have had your say; now it is my turn."

Mr. Tony O'Brien: Yes. I have had that reported to me as being one of the things that was said this morning. As I said, that will be in the transcript and be part of the investigation pro-

cess.

There is the question of the Minister's term of "lied". I watched some part of another "Prime Time" programme in which there was not open disclosure or candour, so the truth was not told. I would not call it a lie at this stage but I understand why that term would be associated with it.

Deputy Caoimhghín Ó Caoláin: It comes to the same thing for most of us.

Mr. Tony O'Brien: It does but in the nature of a disciplinary process, I must be just a little more careful. I believe the issue of open disclosure would be better placed in a legal construct. I personally am in favour of a legal duty of candour. That would be in everybody's interests. The open disclosure policy we have pursued does not currently have a legal framework underpinning it and it is mandated within the organisation. It is being used very extensively but it was not in place at the time.

There is the issue of the implementation of previous reports. There is acknowledgement that the recommendations of the Ennis and Mallow reports have been implemented. Clearly, they were not fully implemented in Portlaoise as to do so would have conflicted with a policy position of the Government. The nature of the reconfiguration of the remainder of the small hospitals, as per the small hospitals framework, has occurred. It would not be appropriate to suggest that there has not been implementation of those previous reports. With regard to the O'Malley report, I played a key role in the implementation of the national cancer strategy, which had the effect of implementing many of the recommendations in the report. Dr. O'Reilly has played a continuing role in that regard. There has been very significant implementation - completed and ongoing - with respect to the HIQA inquiry that I asked for with regard to the death of the late Savita Halappanavar. There has been significant implementation that is ongoing with regard to the recommendations of the chief medical officer. There are some generalised comments about failure to implement but when one considers the detail of those recommendations, there is very substantial implementation. There was a combined oversight group with the small hospitals framework that included HSE, Department of Health and HIQA representation.

With regard to the implementation of further recommendations, the model that occurred with respect to the small hospitals framework - the so-called Ennis and Mallow framework - is good. One of the recommendations of HIQA is that the Minister would put in place an oversight mechanism to monitor implementation. That mirrors what happened on that occasion. The Minister has committed to doing that and it is appropriate. Where HIQA has indicated it is for the HSE to implement recommendations, it is because the HSE needs to implement them. The HSE is the only body that could implement them, it will do so and it will be supported in doing so by the oversight mechanism the Minister has referred to.

The State Claims Agency issue is a reference to a section of the report. It is a reference to a review in Portlaoise referring to meetings that took place approximately eight years ago between State Claims Agency representatives and managers from what was then called the midlands hospital group. The first meeting, which took place in November 2007, discussed the potential order of maternity services at Portlaoise hospital. That meeting considered the need to conduct the proposed audit in view of the fact that the hospital had identified and accepted the problems that were of concern to the State Claims Agency, had an action plan in place to address them and was conducting a related incident investigation. A further meeting was arranged in December 2007, at which it was agreed that in light of the information provided by the hospital and the HSE after the November meeting, a review of the maternity service in Portlaoise was not required at that point in time. That is a position that has been discussed and

it is an agreed position, as it were, in terms of what happened at the time between the HSE and the State Claims Agency.

The truth is the HSE has an extremely good working relationship with the State Claims Agency. Personnel across the health service have multiple interactions with the agency at various levels and on an almost daily basis. This relationship is a critical component of risk and incident management across the health service. Since the time referred to in the HIQA report, the State Claims Agency has also augmented its own approach and makes earlier and more direct contact at senior levels both within hospitals and-or with HSE management where this is required. This process is fully supported by the HSE and involves formal interactions at a national level between the two agencies.

Chairman: Would you say that the HSE has due regard for the State Claims Agency's patient safety data?

Mr. Tony O'Brien: Yes, although a new system called the national incident management system or NIMS has been rolling out since January of this year. This involves a process that will give the corporate divisions of the HSE direct access in real time to that data. Currently what happens is that the State Claims Agency runs reports on request. In future - and this will be sorted out as part of the planned process for the implementation of this system - at corporate level there will be direct access to that data which there is not at present. There has been an historical issue about access to data in voluntary hospitals and that is being resolved at present. That will provide a much more cohesive system. NIMS, when fully deployed, will enable the HSE to roll in aspects of our own quality and patient safety tracking systems so that there is a single system and the coding to enable the serious reportable events to be captured on that system is currently being put in place. It will then be a singular system.

Dr. Susan O'Reilly: Portlaoise is fully implemented in that.

Mr. Tony O'Brien: Portlaoise is fully implemented in that regard already.

On the issue of inquests, obviously where there is to be in inquest, that is a matter of statute and the inquest must proceed. As Dr. Crowley has said, in the past - and I do mean the past - there was a culture whereby the point at which a medical negligence or other claim against the HSE or the State was initiated had an impact on relationships and the ordinary process of engagement. This came into particularly sharp focus in the context of persons suffering from narcolepsy who may have that condition as a result of a vaccination process, where there was a suggestion that certain supports would be provided only to persons who were not engaged in legal action. I intervened at that time to make it absolutely clear that the relationship between the HSE and its patients or clients must not in any way be affected by whether individuals had or had not initiated legal action. In the past, as Dr. Crowley has said, that was an event that occasionally interrupted the normal process but that is no longer the case and should never have been the case.

On the use of freedom of information requests, the Freedom of Information Act should never be something that patients have to rely on. I am familiar with the fact that Mark and Róisín Molloy had issues in that regard. When I met them with Ian Carter last year, we ensured that they received every piece of documentation that was connected with them. The method we used was that anything that had their name on it or the name of their late son, Mark, was provided to them at that point. It should have been provided sooner. It is absolutely clear that patients are entitled to their information, to information relating to them or to information relat-

ing, in this case, to their late children. That is very clear.

I hope that I have not overlooked any of the questions posed.

Chairman: We will bring Mr. O'Brien back in again if there are any outstanding questions. Seven members have indicated their desire to speak so I would ask them all to be brief. Deputy Regina Doherty is next.

Deputy Regina Doherty: First of all I would like to say that I wish Dr. O'Reilly the very best of luck. There has been a considerable loss of trust in the services being provided at Portlaoise and she has her work cut out for her. That said, I genuinely wish her the very best.

Mr. O'Brien came in here this afternoon and in his first correspondence with us he spoke about costs and resources as an issue with regard to the provision of services. I am curious as to why, given that we all defended the HSE service plan for 2014 in which patient safety was mentioned in the opening paragraphs somewhere between five and ten times. Given our concern for patient safety, when it was discovered the Midland Regional Hospital, Portlaoise was 16 midwives shy of the number required for a hospital with a 24/7 accident and emergency unit and that the one consultant was only working four days a week, why did top management of the hospital or the HSE not react by either closing down the services or at that point decide to resource them? Why did it take the "Prime Time" programme on the awful tragedy the Molloy family experienced in the hospital before Ian Carter went to Portlaoise?

With respect, when Mr. O'Brien talks about the HIQA report being a watershed with changes being made now, did the 86 families whom the Minister for Health met last night, who in the past number of years had told their stories and testimonies to the senior management in both the hospital and the HSE up to office of the director general not of itself sound an alarm bell to signal that something was wrong with the delivery of services? Did top management not realise they would need to go to Portlaoise and address the issues arising from the services? Did the top management need to wait for a "Prime Time" programme or a HIQA report to deal with the problem?

When Dr. Philip Crowley wrote to me, his title was national director of quality and patient safety, but today he is listed as the national director of quality improvement. Is that not ironic? If Dr. Crowley is no longer in charge of patient safety, who is responsible for this role? During the time he was in charge of patient safety, which was until at least February of this year, how many times did he go to the Midland general hospital to discuss the adverse incidents that had happened in the hospital and the actions that would need to be taken? The report of the inquests made recommendations on the changes that needed to be implemented. How many times did Dr. Crowley discuss with the local management how the changes should be costed, resourced and implemented?

I have major concerns about the quality patient safety directorate, but as I do not want to bring the committee into disrepute, let me state that personally, I have no trust or confidence in Dr. Crowley's ability to manage the patient safety authority. The facts speak for themselves. We have had so many adverse incidents during his period in charge, and not just in maternity service, that if I were in that role I would be questioning how we are actively looking at patient safety.

Senator Colm Burke: I thank the witnesses from the HSE for their presentations. I wish to touch on the perinatal mortality rate, an issue that was raised this morning. I tabled a com-

mencement matter in the Seanad on 14 May on the need for the Minister for Health and the HSE to publish the 2014 perinatal mortality rates for each of the 19 maternity hospitals in view of the recent adverse media coverage on this matter. The Minister replied to me on 14 May, but I have not got the figures for each individual hospital. He stated:

> The notification of still births is a mandatory requirement in the Civil Registration Act 2004. This Act was amended in 2014 to make notification of early neonatal death mandatory. The general registration office is working on the commencement of this.

Who is obliged to do the reporting? I am a little confused about the registrations. Is it the hospital or the parents who are obliged to report the death? In his letter of 14 May, the Minister further states: "The general registration office is working on the commencement of this". When is it likely to be commenced so that we have a proper system in place?

Another issue raised in the letter was about clear definitions. I know Professor Greene raised the number of different ways of approaching the issue. Can we have a clear definition at this stage? Are the figures for 2013 available? When is it likely that we will have the figures for 2014 in respect of each of the 19 units?

A report was produced in 2006 about the need for further midwives in Portlaoise. In the body of the report the Institute of Obstetricians and Gynaecologist recommended that the Coombe Women's Hospital and the Midland Regional Hospital, Portlaoise would work together, yet it took a number of years before that happened. As we have touched on the recommendations in respect of the hospitals in Galway, Ballinasloe, Portlaoise, Cavan, are there recommendations that were made six, seven or eight years ago in respect of other units around the country, that have not been implemented? When are they likely to be implemented? It is important that we do not wait for another tragedy to arise before these recommendations are implemented. I ask the witnesses to deal with that in the context of other maternity units.

On page 92 of the report on Portlaoise reference is made to access to theatre. Is a solution being proposed for that problem? I understand that access to theatre is also an issue in a number of other maternity units which are sharing theatre space with the general hospital. Have those units been identified and what programme of action is proposed to resolve this difficulty? How many units do not have dedicated theatre space and for how many units will this problem be resolved? When is it proposed to deal with the theatre issue in Portlaoise specifically?

Chairman: Deputy Mitchell O'Connor is next.

Deputy Mary Mitchell O'Connor: This morning we heard harrowing reports from the parents of Mary Kate and Mark. They were upset, staff were upset and so were members. I thank Dr. Crowley for apologising. Has Mr. O'Brien apologised to the parents for what has happened? I may have missed it. Dr. O'Reilly has reported that things are improving and new systems have been set up. Can I have a watertight guarantee that what happened to baby Mark's parents, in terms of them e-mailing back and forth, trying to get information, will never happen to another parent who loses a child in a maternity unit? I was very concerned when I heard baby Mark's parents state that he was registered as stillborn. Is this normal practice in a hospital when a baby lives for a short time after birth to register that as a stillbirth?

I asked the parents numerous questions and thought they were very generous in their answers. I commented to the effect that we all know that human error can occur in a hospital. While they agreed and said that they understand that human errors happen, they argued strongly that failures must be investigated fully in order to be prevented in the future. I want to know,

as do the parents, if a formal or informal decision was made by senior HSE staff or senior management in Portlaoise not to act on the human errors that occurred that day. As the parents said, nobody went into work that morning to cause harm. They also said that there are departments of audit, risk management, advocacy and complaints in the HSE. Are all of those departments still in existence and if so, could the witnesses tell us what they do?

I wish to ask the witnesses about the lack of a safety culture in the hospital in Portlaoise, as referred to in the executive summary of the HIQA report. Page 9 of that report reads as follows: "It is also evident that at this time, the hospital's senior management team did not collectively conduct formal safety walk-rounds". Is that happening now and is it happening in the other maternity units across the country? I find it incredible that this is not happening in our hospitals. Were the senior management and the people responsible suspended, reprimanded, put on paid leave? What happened to them?

The parents also mentioned the qualifications of staff that day and the fact that there was no-one available to carry out a CTG test. Had that been done, the baby could have lived. The witnesses have told us that staff are being trained in cardiac monitoring. Is that the case in other hospitals? Can a mother who is to go into hospital this evening tonight or tomorrow to deliver a baby expect the staff to have been trained in cardiac monitoring?

Chairman: I ask the committee to break with precedent and allow Deputy Creighton, who has another appointment to go to, to come in next.

Deputy Lucinda Creighton: I thank the Chairman and members. I do not often beg indulgence but I appreciate it. I am anxious to ask one or two questions of Mr. O'Brien. We were told today by the parents of two babies who died in Portlaoise that the HSE management is clearly incapable and cannot be trusted. They told us that information was deliberately suppressed, as were known red flags. The story goes on and on and it is apparent from the contents of the HIQA report and the evidence this morning that there are huge failings at all levels - national, regional and local. Ms Amy Delahunt also told us this morning that the director general of the HSE must stop misinforming the public that these events were before his time with the HSE.

A number of instances of correspondence were drawn to our attention, which I want to raise directly with Mr. O'Brien. First is a letter of 26 October 2012 in which Mr. O'Brien wrote to Mr. and Mrs. Molloy saying, "I am disappointed to learn from your letter that you were unable to get an adequate response previously but I can assure you that Dr. Philip Crowley will actively deal with this matter." On 25 November 2012 the Molloy family, Mark and Róisín, wrote to you in your capacity as director general of the HSE, the head of the organisation. They said, "We cannot begin to put into words just how frustrated, appalled, angered and upset we are". In a lengthy piece of correspondence, they went on to say:

> We are not the only family whose baby has died in worrisome circumstances in the hospital in recent years, yet there seems to be a blatant ignoring of this hospital's obligations in relation to having these deaths investigated. What is even more concerning is to learn that, despite these deaths and birth injuries to other children, this hospital has never been audited.

The Molloy family implored you, they appealed to you, as director general of the HSE to act to ensure that no other family would suffer the way they had at the hands of the HSE. Thanks to their assiduous work and through their resourcefulness we have also been made aware that a meeting took place on 6 December 2012 between Mr. O'Brien and Dr. Philip Crowley at which there were two agenda items.

Chairman: I ask the Deputy to finish and I remind her not to name names.

Deputy Lucinda Creighton: The first item on the agenda was baby Mark Molloy and the reporting relationship. No minutes of the meeting are available but it is documented and it did occur. How can Mr. O'Brien say that he is not responsible, that he was not there and that he had nothing to do with it? We know that other deaths occurred in 2013 after these appeals by the Molloys to Mr. O'Brien as director general of the HSE. How can Mr. O'Brien say that he is not responsible and how can he not feel in any way accountable for these occurrences? I cannot comprehend how he can suggest he is not responsible given that he was directly written to on a number of occasions and he attended meetings where this issue was addressed and nothing happened.

Chairman: The next speakers will be Deputy Healy, Senator Gilroy and Deputy Catherine Byrne.

Deputy Seamus Healy: I am due in the Chamber to speak on Private Members' business shortly so I thank the Chairman.

The HIQA report confirms, in all material respects, the experiences the families had at hospital level, at local level, at regional level and at national level. I understand the HSE, including Mr. O'Brien, had concerns over the draft report. The report is out now. Does Mr. O'Brien accept the HIQA report, as published? Will he commit here to implementing its recommendations? Can he give us a timescale for the implementation of the recommendations of the report in so far as it refers to the HSE?

As we all know, the report is shocking and damning. One of the points that is most difficult to understand is the lack of humanity and compassion for the families during this whole nightmare. Can Mr. O'Brien give any explanation to this committee and the families as to why the latter were treated with such a lack of humanity and compassion?

The report shows failures at all levels of the HSE. It shows a dysfunctional system with systemic failure and what would appear to be a culture of inaction. Does Mr. O'Brien accept that there have been failures at all levels, locally, regionally and nationally, in regard to this matter?

Let me outline a matter the families are particularly annoyed about. They believe, and have said here this morning, that the HSE was involved in a cover-up and that they were encouraged to sue in the hope their doing so would deflect investigations. One family - Ollie and Amy - told us they were told by the staff at the hospital that they were the only family that experienced this particular difficulty. Of course, they heard since that numerous families were told the very same thing. One wonders whether this was a policy of the hospital and the HSE. There was certainly misinformation, and it must have been deliberate misinformation. Can Mr. O'Brien indicate how this could have arisen and how the family could have been given misinformation deliberately?

The question of staffing was also raised. It was raised in 2006 and again in 2008 but not acted upon. Despite this, it was possible to act on it when these difficulties arose. Families would like to know why, when these difficulties concerning staffing arose, they were not dealt with at the time.

Does Mr. O'Brien believe the HSE is fit for purpose? Is it capable of running the health service? Does Mr. O'Brien accept that only an independent inquiry into this matter would be capable of bringing an end to the nightmare experienced by the families?

Senator John Gilroy: Mr. O'Brien started his contribution today by acknowledging the convention that contributions are circulated in advance, but he deviated from the convention. Why did he not circulate his response to us?

Chairman: There is no obligation on any witness appearing at any committee, be it a Minister or a witness we have invited, to provide a written script or to have one.

Senator John Gilroy: I understand that but I was just curious about it. That leads me to my second point. At this morning's session we heard powerful and moving contributions from the families. The one message that I heard very clearly concerned the difficulty in obtaining information. I am very frustrated by what I am hearing this afternoon because in my view, Mr. O'Brien's contribution bears very little relation to the HIQA report. His response was defensive, reflexive and legalistic, with more regard to process than to explaining. That is what I am looking for today but I am no closer to getting an explanation now than I was before the meeting started.

We have heard about the legalistic and regulatory obligations, disciplinary procedures, oversight, implementation programmes, cultural shifts and so forth. We even heard terms like "subset of a directorate". The submission was laden with jargon and seemed to be designed to obscure the issues rather than to enlighten us. I am sorry for being so harsh but this is how I feel about it. Mr. O'Brien seemed to be suggesting that one of his concerns about the HIQA report was the absence of reference to individuals.

Mr. Tony O'Brien: Could the Senator repeat that please?

Senator John Gilroy: Mr. O'Brien seemed to be suggesting in his contribution that his concerns relating to the HIQA report were primarily due to the absence of reference to individuals. I ask him to elaborate on that point.

Mr. Tony O'Brien: I did not say that.

Senator John Gilroy: He did say that. Finally, when there was talk about legal obligations and judicial reviews, did Mr. O'Brien have any regard to how the families might have felt on hearing such public pronouncements at a time when one of the most emotive topics was being discussed widely in the media?

My final point relates to cutting budgets in the areas of training and advocacy. I would have thought that during times of constrained budgets, these are the very areas where budgets should be maintained, if not expanded, in order to maintain quality of service. I ask the witnesses to comment. I am sure they can hear the sense of frustration in my voice but I feel that I am no wiser now than I was before they spoke.

Chairman: Deputy Byrne is next. We left the best wine to the end.

Deputy Catherine Byrne: The Chairman should not say that. He is raising expectations. What happened in Portlaoise hospital is a reflection of very bad management. Mr. O'Brien referred to compassion seven times in his opening statement. He spoke about not doing unto others anything that one would not like done to oneself. However, for the families that were here this morning, there was no compassion. One woman reflected on the lack of compassion she had experienced following the loss of her baby, recounting that a small, simple act of humanity would have provided much needed comfort during that moment. When one has to bury a loved one, it should be all about compassion and humanity in a hospital. If that is not there, then the

whole basis of the health service is lost completely.

Page 8 of the executive summary and page 21 of the main HIQA report reads as follows: "However, it is apparent that despite overwhelming evidence to indicate that the local management team at Portlaoise Hospital was struggling to deliver the service, there is no evidence to show that regional HSE managers took effective control of the situation at that time." That is the key issue. Why did nobody call in the fire brigade when it was known that there was a problem? The situation could have been approached in a totally different way.

I was very happy to hear Dr. O'Reilly speak about the link between the Coombe and Portlaoise hospitals. Has that happened yet? I am listening, but I am hearing different accounts of it. If it has not happened, why has it not happened? When will it happen? Something needs to happen in the Midland Regional Hospital, Portlaoise. As Dr. O'Reilly said, steps have been taken to ensure that a proper service is being provided.

I read this report right through. It was the most chilling report I have ever read. Some parts of the report were a nightmare to read. Mr. Ollie Kelly finished his contribution this morning by saying it was unforgivable what happened to his beautiful Mary Kate.

If anything is to come out of this meeting for the families who are here, it is the need to put in place a healing process for them and everybody else who was affected by what happened in this hospital. If that does not happen, I do not think the HSE will ever manage the hospitals it runs. There is healing when people sit down and listen to each other but there must be compassion and humility. I am speaking from recent experience of burying a family member. When we were around the bed of the person last week, it was all about compassion and humility. If we cannot have that in a hospital situation, we might as well forget about it.

Mr. Tony O'Brien: I was asked why I did not provided a written statement. The reason is that essentially I found it almost impossible to write one. Each of my statements I make are written by myself, but when we have our quarterly meeting, there is much input from many colleagues. When I sat down to write a statement for today's meeting, I was able to identify the areas I wanted to talk about, but not to write it. I wanted to appear before the committee and speak on the issues without reading from a script as I would have felt uncomfortable reading from a script in the circumstances. It is not the case that I had a script but did not provide it to the committee. I did not have one. I gave the committee the headings. For myself, I had written down the key words to remind myself of things that I thought were important to mention.

I regret that Senator Gilroy does not feel in any way enlightened, that is unfortunate and suggests we failed somewhat in our task today. We will reflect on that. He asked whether I had considered how families might feel in the context of the discussion I have had with HIQA. It never entered my radar to expect that within 24 hours of having had the meeting with HIQA, having agreed a way forward, being provided with additional information and having been given a timeline within which we could respond, that it would find its way into the public domain and be presented in the way that it was. I had no expectation that would occur. I think it is reasonable that I would not expect that to occur. I would expect to be able to engage in discourse with any regulator and for that process not to result in the type of thing that went on. Inevitably that has caused all sorts of concern among those who are at the centre of this investigation. It was suggested that we were attempting to ensure that there would be no report. That was never the case. All I wanted to do was to be facilitated to deal with what was asked of me, which was to make a submission that would be part of the normal process.

There are things in the report that would not be there if the submission had not been possible. I have already outlined some areas in the report where I think there is room for further improvement. We have already covered that ground. I agree with members that it would have been better in the years from 2008 to 2012, inclusive, if training budgets had not been cut. When I became effectively the acting chief executive officer after being designated as the future director general, my first action was to begin to restore training budgets. What we experienced in those years was unavoidable. The situation the country faced meant that emergency measures had to be taken. There is no question about that. However, they had quite a corrosive effect on the relationship between managers and staff at all levels in the service. A significant amount of talented managers and leaders left the organisation. Others had to assume their roles without the benefit of enhanced training to facilitate them.

One of the things I reflected to HIQA and previously in this committee is spelled out in the service plan for 2014. All that focus in public discourse on budget overruns, deficits, staff head counts and too many administrators - all those headlines we have all seen - drove many levels of the HSE and the organisations it worked with to become excessively concerned about those issues, often to the detriment of being able to spend time focusing more on other issues such as access, quality and safety. The committee will find a reference to comments I made in the report that are also reinforced by HIQA's reading of correspondence I had with the Department where I said back in 2013 that we needed to renew the focus completely on quality and patient safety. I cannot tell the committee the page number. I think it is in the final chapter. I made that reference to the investigation team as part of seeking to secure its understanding of what I was about, that five years of that does not get turned around terribly quickly and that I am in the process of doing that. I wanted the team to understand by giving it the letters of determination and the head count reduction targets, none of which has ever been met while I have been director general because I have not really prioritised the head count reductions. I do not think they are sensible. They often increase costs and reduce safety. I have always told everyone that across the four factors performance is measured by, one of which is the use of human resources, achieving arbitrary head counts is the least important. As the Chairman is aware, I have often got myself into some trouble for the stance I have taken on some of those things.

In response to Deputy Regina Doherty-----

Chairman: Notwithstanding the remarks made by Mr. O'Brien and the issue of resources and training, some of the things that happened to the parents and families involved obfuscation, procrastination, delays in answering questions and a lack of courtesy. I once worked as a hospital porter in Cork University Hospital. We were told three things: to respect the patient, treat patients as human beings and always remember where we were from. That was not done in this case. One can have all the money in the world, and I accept what Mr. O'Brien is saying, but the way the families were treated in some cases was beyond human decency. It was lacking in human decency.

Mr. Tony O'Brien: I accept absolutely what the Chairman is saying, but if we are to have a really grown-up discussion, which the people in the room want, we must discuss both of those things. My first remarks were about compassion. I did not realise I said it seven times. Deputy Catherine Byrne reminded me of that. No one here is seeking to explain or excuse any of that but that does not mean we should not also talk about some of the resource issues that have affected the Midland Regional Hospital in Portlaoise or other hospitals. It would be unfortunate if we got into a situation where because there was an inexplicable and inexcusable breakdown in care and compassion or compassion in care, this is the only discussion we need to have be-

cause it is not. Any reports on this situation in the context of where the health service has been and where it needs to go that do not address the fact that we have only half the obstetricians in this country that we need is missing half the point. While in some respects I would be on much safer territory coming in here and just saying that we should only talk about why people behave badly, I would be in dereliction of my duty if I did that. I want to be open and honest with the committee about that.

There were specific questions about theatres and other issues in the Midland Regional Hospital in Portlaoise and other places. I will ask Dr. O'Reilly to talk about the situation at Portlaoise and I ask Mr. Woods to talk about the national situation.

Dr. Susan O'Reilly: There was a question about access to theatres, relating to page 93 of the HIQA report. The issue here was less about access to theatres than access to a surgical team if there were two consecutive urgent or emergency caesarean sections. There are two theatres in Portlaoise. The bulk of the work in the theatres is obstetrical and the issue that arose is what would happen out of hours, at night or on the weekend, if two mothers required an urgent caesarean section. This only occurs perhaps twice or three times a year, because the theatre space is there. Last autumn, Portlaoise put in place a back-up clinical team, so it can have the additional doctors and midwifery staff on call and two simultaneous caesarean sections can be carried out should the occasion arise. That issue has been addressed.

Moving to the broader questions about guarantees regarding the disrespectful or lack of compassionate behaviour towards the mothers or parents involved where a baby has been lost through a stillbirth or a neonatal death, I can give the committee my absolute commitment for the two maternity services within our group, comprising Portlaoise hospital and the Coombe, that engagement with the family will happen immediately. It must. In my clinical practice, and I am a medical oncologist cancer specialist, and also in cancer leadership in Canada and in this country, I learned the lesson many years ago that one is only making the families or the patient increasingly miserable, angry and hurt if one does not engage immediately. One is doing no favours if staff back-off from the situation, perhaps out of their own anxieties or distress. That engagement must be there and it must be compassionate. One must have bereavement support for patients and psychological support where needed. It absolutely must be provided. I make my personal commitment on that.

One can never guarantee that babies' lives will not be lost. The committee has heard Professor Greene talk about the small numbers of babies that are documented as dying around childbirth, but the issue is how one deals with it. It is absolutely critical that we adopt and implement fully the open disclosure and also the patient support. It is still an excruciating experience, but the one message I have heard most frequently from all of the parents involved is that they do not want their child's death to be in vain and that they want to see change. I believe change is happening and will continue to happen.

In general terms, I cannot comment on the history of what took place in individual situations in 2012 and 2013. I was heading the cancer control programme then and I only got engaged in the hospital group leadership in November 2014. I cannot say anything relevant to that because I do not have that historical data. Perhaps Dr. Crowley and Mr. O'Brien could comment if necessary.

Again, I will not address the HSE approach to audit, advocacy, risk and complaints. However, as I already mentioned, we have a very effective complaints process and complaints officer in Portlaoise now. Complaints are almost all resolved within the 30 days required. An

advocacy programme is beginning and we have a very highly skilled individual on site who will begin her work at Portlaoise but will roll it out for the other hospital groups as well under Liam Woods's leadership. We are doing clinical audit. We are not auditing absolutely everything, but we are auditing that we have the full engagement of the maternity staff in using all of the early warning requirements to monitor patient progress. That is carefully audited. The risk management processes have up-scaled substantially. Risks are being managed, documented, reviewed and recorded.

As an aside, I have taken over commissioning some of the investigations that were already ongoing. I agree that some of them have taken too long. I also agree that part of the issue is that it is not easy to have obstetricians or other clinicians volunteer their time to do this work on top of their day job. They also require indemnification from their professional bodies and a number of other structures to be put in place. However, I can certainly commit regarding any of the reviews I have taken into my office that if anybody gets in touch with my office we engage right away and if reports are to go out we are endeavouring to get to the end of the road. There are still some legacy delays that I am endeavouring to manage at present and some communications, but that is ongoing. That includes some of the work being done by Dr. Peter Boylan and his team in respect of maternity complaints.

Walk-arounds are happening. The culture of safety is embedded in the maternity services at Portlaoise hospital and also is in progress in the general hospital services. In regard to the operation of continuous cardiotocographic machines, CTGs, all midwives receive the required training as part of their electronic module. Each new member of staff is signed up to attend a workshop, with workshops being held approximately every two months. Staff are mandated to undertake the electronic training and, in addition, shift supervisors and the director of midwifery will supervise, engage and continue to instruct. Learning does not just involve a single e-module or workshop; it is a continuous, lifelong clinical improvement project. It is important to state we now have people well trained at the midwifery and junior hospital doctor level and that we intend to sustain this. In addition, we have staff trained in ultrasound technology to a higher degree than was previously the case.

I hope I have covered all of the questions addressed to me by members.

Mr. Liam Woods: Regarding access to emergency theatres, there is that access in the standalone maternity units and general hospitals. There have been changes in Cavan recently, for example, to ensure the theatre roster allows for this.

Mr. Tony O'Brien: My colleague, Professor Greene, might respond to the question about reporting and the classification of stillbirths and neonatal deaths.

Professor Richard Greene: This is probably a somewhat dry subject for many people, particularly those who have lost babies, but I will endeavour to clarify the point raised by Deputy Mary Mitchell O'Connor. The legislation refers to a stillbirth as involving a baby without signs of life at the time of birth, while a neonatal death is considered to occur if the baby dies after birth and has shown signs of life. However, there is no definition or description of what is encompassed in "signs of life". Essentially, if there is a heartbeat or gasp, it is taken as the baby having shown signs of life.

Deputy Mary Mitchell O'Connor: To clarify, if a baby dies after, say, one minute, it is classified as a neonatal death?

Professor Richard Greene: Yes. A baby might have a heartbeat that is gone in one minute or give a gasp and show no further sign of life. Where any such sign of life presents, it is considered to be a neonatal death.

There were several questions about reporting and registration. Registration of stillbirths is required where the woman is at more than 24 weeks gestation or the baby weighs more than 500g. Reporting in this regard comes either from the likes of the ESRI or in the audit-type work we do. There is also a requirement for certification of death, which occurs at some subsequent point. The requirement is that the doctor complete the death certificate for the baby, but it then may be given to the parents to submit to the General Register Office. The report on Portlaoise hospital suggested we review this procedure. Dr. Crowley and I met the chief medical officer, CMO, and subsequently the healthcare pricing office, HPO, to discuss the issue. As a consequence of these discussions, we have agreed to follow in the future the World Health Organization definition, which is that baby deaths will be documented in the statistics if the baby weighs more than 500g.

A question was asked about the publication of reports for 2013. The perinatal statistics for that year were published in December 2014 by the HPO. The 2013 clinical audit of the data we receive will be available later this year. It requires a lot of clinical information and there is sometimes a delay in the data for final cause of death arising from referrals to the Coroner Service.

Mr. Tony O'Brien: There was a question asked about the escalation of staffing issues in Portlaoise and Ms McGuinness can speak to that.

Ms Laverne McGuinness: The member asked why 16 nursing staff had only now gone in and if this had not been addressed beforehand. Staffing in Portlaoise was addressed on a number of occasions. As members are aware, a moratorium was introduced in 2009, under which nursing staff could not be replaced. However, in October 2010 Portlaoise hospital was short particularly in its midwife staff and staff in the special care baby unit. In October 2010 five additional midwives were sanctioned for nursing staff at the special care baby unit. They went in between February and March 2011 because it takes a period of time to recruit.

Again at the time, members will recall the grace period when there was a large exit from the public sector based on troika agreements. That was supposed to be based on a non-replacement policy in order to deliver the amount of money that was required for Government at the time, but we carried out a risk assessment particularly regarding maternity services at Portlaoise. At that time we asked the hospital to carry out a risk assessment with its clinical director, nursing director and regional director of operations. Based on the number of staff that were due to leave at that time, seven midwives were replaced as were one nursing staff member in the special care baby unit, two nursing staff in the emergency department and one obstetrician. The hospital clinically and risk-assessed it at the time, and that was the staffing that was required. There was certainly a dip in staffing levels but these have improved significantly since 2013. We have statistics on that.

Chairman: I ask Mr. O'Brien to address Deputy Regina Doherty's points.

Mr. Tony O'Brien: Yes. There are also some from Deputy Healy.

Chairman: I am conscious that it is 5.40 p.m. and we have been here since 11.30 a.m. bar half an hour at lunchtime.

Mr. Tony O'Brien: Is the Chairman's guidance that I should address Deputy Doherty's questions?

Chairman: Yes. I will leave it up to Mr. O'Brien. I am conscious that there are outstanding questions, but we have been here since 11.30 a.m.

Mr. Tony O'Brien: I am happy to be guided. There was the issue of the 86 families the Minister met last week. I believe Dr. Susan O'Reilly was there also.

Dr. Susan O'Reilly: I was there.

Mr. Tony O'Brien: Deputy Doherty is right. It is a very significant number of people to have had very bad experiences over, I understand, a very long period of time as well as more recently. I understand from the Minister that at least some of those present were relating experiences they had as far back as the 1980s. This is not a new problem and neither is it an old one. It is a problem over a long period of time.

The Deputy asked about the patient safety authority and Dr. Crowley's change of job title. When I appeared before this committee to discuss the 2014 service plan, I outlined some of the changes. I said, "I emphasise there always is a danger, when one has someone who is identified as the director of quality and patient safety, that it could be perceived, either internally or externally, that it is that person" who is responsible solely for quality and patient safety. When the directorate was established which for the first time had people at national level responsible for social care, mental health, acute services and so on, they, as part of their work, accept and take on responsibility for quality and safety in their areas of responsibility. The functions of the director of quality and patient safety were a blend of quality improvement works, such as running the IHI programme for leaders in quality improvement and managing investigations, and a variety of other things. However, they are not actually responsible for the services themselves and therefore are not accountable for failures of service.

Deputy Regina Doherty: So who is?

Mr. Tony O'Brien: I will continue my answer, if I may, and I will include an answer to that. A bit later in 2014 and partly in response to what had happened in Portlaoise and some of the work that Mr. Ian Carter did, I decided to make a further change to break up the quality and patient safety division, and have one entirely focused on quality improvement activities, which is working with staff around the application of evidence as to what improves quality. Dr. Philip Crowley leads that division while a second quality assurance and verification division which leads investigations, overseas complaint handling, and is changing the way we do complaint handling and operates, if one can use the term, something like an internal HIQA. In other words, it has a mandate from me to go anywhere and everywhere and conduct its own initial investigations to improve matters. That explains the change in the title.

Deputy Regina Doherty: Who is in charge of it?

Mr. Tony O'Brien: Mr. Patrick Lynch, who is not with us today and who I think I am right in saying took on that role in December. It is set out in the 2015 service plan. It is also a series of changes that have been acknowledged and welcomed by HIQA, notwithstanding the fact, as I acknowledge, that it is still early days. We do not yet know what it will do, but in design terms it is appropriate.

In each of the five divisions at national level it is the divisional national director who has

responsibility. In each of the hospital groups it is the group chief executive who has responsibility. In each of the community health organisations which are at a slightly earlier stage of development it is the chief officer who has responsibility. To answer Deputy Seamus Healy's question, a single, national blob-like entity, if I can use that term, that has all of the responsibility at the centre and which is not appropriately diffused is not fit for purpose. As I said in my opening remarks, when I took on the job, it was on the basis that I could make these changes, which are consistent with the programme for Government and the Future Health strategy, in a reasonably timely fashion but only in line with the various policy decisions when made. By the end of the year we will have a much better structure delivery system from the point of view of named people with real responsibility for defined parts of service delivery and others who have more of a commissioning role, which is the long-term intent for how the health service will be organised. I hope I have answered that question.

On the patient safety authority, now more appropriately referred to as a patient advocacy entity, we had done some work, but the Minister will take it forward and establish it as a body or perhaps as part of an existing body which will be in a position to help people to navigate what is, by any means, a very complicated system and act as an advocate in the common sense of the word to ensure there is professional support available to an individual who is seeking redress, information or answers from what is a very large, complex and unwieldy system.

Deputy Mary Mitchell O'Connor: This is not a new question-----

Chairman: No-----

Deputy Mary Mitchell O'Connor: I asked Mr. O'Brien about the apology and if staff had been reprimanded in terms of fitness to practise or whatever else.

Mr. Tony O'Brien: I have apologised publicly before and I am happy to do so again. I have met Mr. and Mrs. Molloy before but not Ms Delahunt or Mr. Kelly. If the opportunity arises before we leave here today, I will also seek to speak to them. I have had some contact with other families in the light of the public apology I made previously who have been remarkably magnanimous in their response.

There are references to the regulatory fitness to practise processes for four staff members. There are others who will be subject to the disciplinary investigation process I mentioned in my opening remarks, the terms of reference for which will be published this week. They have been half-published. They are in what is known as a speedy procurement process because we have to go through a procurement process to bring in senior people from outside the State to do it. They will be finalised and probably by this day next week, everyone will be aware of them and the individuals who will be charged with leading them.

Chairman: How long will that process take?

Mr. Tony O'Brien: I expect the process to take approximately three months to complete from beginning to conclusion. That is what is in the-----

Chairman: I am sorry; I did not hear what Mr. O'Brien said.

Mr. Tony O'Brien: I am sorry. I expect the investigation, from commencement to conclusion, to involve a period of about three months. Where individuals are referred for disciplinary hearing, there is a set procedure which will be followed in each case.

Chairman: At the end of that process there will be accountability.

Mr. Tony O'Brien: Yes. The Health Service Executive's disciplinary code which is consistent with the standards required of a public body has four levels. It has been published and is on the HSE's website. Based on what the investigator finds, the explanations will be put forward by any individual facing a disciplinary hearing. The panel which will hear them will then decide, first, if a case has been shown and, second, what is the appropriate response from an accountability point of view.

Chairman: Deputies Ó Caoláin, Kelleher and Mitchell O'Connor have indicated. I ask them to limit themselves to one sentence please.

Deputy Caoimhghín Ó Caoláin: Just one sentence will not manage it, but it is one point. It is the response that Mr. O'Brien gave earlier to my question on the HSE's efforts to close down the "Prime Time" investigation programme. I am reliably informed that every effort was employed by HSE representatives to dissuade the RTE investigation unit from proceeding with its planned programme. HSE voices claimed that nothing untoward had happened. They claimed further that there was nothing unusual whatsoever in the baby death or deaths that had taken place. They attempted to emphasise the normalcy of such child deaths.

Any participation by the HSE in the programme is described to me as reluctant and against a backdrop of persistent discouragement. There may not be a paper trail, but I am told that everything imaginable was employed by these HSE voices to secure a suppression of the programme. If Mr. O'Brien is unaware of that, I would ask him, among all the other things he has undertaken to investigate, to do so in this matter as well. If anyone doubts the veracity of this, it can be verified through appropriate enquiries.

Chairman: I concur with Deputy Ó Caoláin. The information I have from two different sources corroborates what he has said.

Deputy Billy Kelleher: I wish to refer briefly to the question I raised earlier. On page 47 of the HIQA report it says-----

Chairman: Is this a previous question or a new one?

Deputy Billy Kelleher: No, it is a question I raised earlier. I would like an answer to it. I was watching on the monitor and I do not think it was referred to. The report states, in summary, that at the time of the investigation Portlaoise was not resourced as a model 3 hospital, that it was excluded from the smaller hospital framework, and that it was awaiting its role within the hospital group set out by the Higgins report.

It was one of the ten hospitals that were initially identified by the HSE with risks similar to those identified in the Ennis hospital report. Subsequently, it was taken out of the small hospitals framework and included as a level 3 hospital. While that was a policy decision, as I asked Mr. O'Brien previously, at what level or when can the HSE say the policy that is being espoused is just not achievable in terms of patient safety? That is critical. While we have Mr. O'Brien in here, we obviously point the finger at him, but in terms of responsibility, when can he say that he cannot implement the policy because he does not have the resources or it is unsafe, even if the policy dictates he should? Surely there is some line of demarcation on that.

As regards any disciplinary actions, who writes the terms for reference for that? Is it the HSE itself or does it bring in outside individuals, or otherwise, in terms of disciplinary action?

The one question I would really like an answer to concerns the issue of Portlaoise and the small hospitals framework.

Ultimately, the HSE representatives are public servants and in that is the hint - the service must be provided to the public. It is always about the public and in every element of that from now on, that should be the clearly defining role of everyone involved in the delivery of health care in this country. Those services are in place for the public, not the other way around.

Chairman: I ask Deputy Mitchell O'Connor to be very brief because she was in already.

Deputy Mary Mitchell O'Connor: I will be very brief. I want to go back to the questions I asked earlier. I want to ask Professor Greene a question again. I know he explained to me about stillbirth and neonatal birth, and I understand that exactly. I want to go back to baby Mark who was defined as a stillbirth. As far as I know, he still has not been recorded in the statistics. Can Professor Greene assure me that baby deaths will be recorded on the impact notification process?

My second question is for Mr. O'Brien. He said he would apologise to the parents. I want to ask him what exactly he will be apologising for.

Chairman: I call Mr. O'Brien.

Mr. Tony O'Brien: In the reverse order, if that is okay.

Chairman: Whichever you want, yes.

Mr. Tony O'Brien: I have apologised for two things. In a number of the baby deaths that were the subject of the HIQA report, there are reports that confirm that there were failings in clinical care. I unreservedly apologise for those. More particularly what I apologise for are some of the more extraordinary aspects of the interaction that we heard about, including the transportation of remains in the boots of taxis or in a biscuit tin, the lack of candour and the lack of compassion. One of the most egregious aspects for Mr. and Mrs. Molloy was the fact that baby Mark was recorded as stillborn even though we know from the investigation report that he lived for a very short but very significant 22 minutes. I know that weighs very heavily in this process. If that has not been rectified, we will take steps to ensure it is rectified in the registration process.

On the "Prime Time" question, I can confirm that I have no knowledge of any of the matters raised but I will make contact with my counterpart in RTE, who is also called a director general, in order that he can explain the issues to me and we can decide how we can progress them. An earlier question was framed around the issue of legal action, but I am certain there was none of that.

Deputy Caoimhghín Ó Caoláin: I do not think Mr. O'Brien can be so sure there was none of that. He will have to wait and see.

Mr. Tony O'Brien: Yes, but my current position pending a discussion with the director general of RTE is that such things did not occur. Obviously, I will approach that discussion in an open-minded way.

In regard to the fundamental question raised by Deputy Kelleher, much of this issue played out in a room similar to this one on 21 July 2011. At the beginning of the meeting, my predecessor, Mr. Cathal Magee, included in his opening remarks a number of comments on the

implementation of the small hospitals framework, which at that point unambiguously included Portlaoise hospital. The HSE took the view at the time, and still takes the view, that the notion of every hospital fitting neatly into models 1, 2, 3 or 4 is not quite right. These are not written on tablets of stone passed down from Mount Sinai; they are broad descriptions. Portlaoise does not fit terribly well in that it has many of the characteristics of a model 2 hospital and yet it has a very substantial maternity service. In some senses, it is model two and a half, if I can use that terminology. Obviously, it also has paediatrics and certain other attributes. Later on at that meeting, at which it appears from the transcript there was a heated enough discussion, although I was not there, the then Minister made a very clear statement of policy.

The legislation makes clear that it is not for the HSE or any representative attending a joint committee to question the merits of Government policy. The Government makes policies and public servants, as in our case, although civil servants in other cases, are obliged to do their best to implement them. I will not, in any sense, question that. However, there was significant dialogue between the officials of the HSE at that time, and I have seen much of the correspondence and spoken to the officials involved, of whom I was not one, seeking to see how the impact of that could be mitigated in all sorts of terms, bearing in mind that the one thing the HSE did not have available to it at the time was any resource or capacity to do what one might have wanted to do to take it out of the small hospital space and fully supporting it as a model 3, as elaborated. The other big challenge it has is that it does not have the level of activity in a number of areas to sustain it as a model 3 hospital.

What we do next will be done carefully because it is not a simple issue of turning something off and hoping things get better. Sometimes if one stops doing things, the situation gets much worse. The 24-7 nature of its emergency department is not sustainable, but we cannot simply stop that until we have made alternative arrangements. That takes time. The hospital's critical care unit is not sustainable for a number of reasons relating to the resources available to it and the level of episodes of care which would be necessary to maintain expertise.

As I said in my opening remarks, it is clear in light of this report that the regulator, which has the power to do so, intends to hold to account those who are in our positions at any point in time irrespective of the resources available to us and irrespective of whether the decisions are made by us or in a policy context. Perhaps it was the regulator's intention to bring sharper focus to this. As director general of the HSE, I can tell the committee very clearly that in light of this development and in light of where we are now, we will take a much more robust approach to all these questions. That is going to be painful. Maybe it needs to be painful. We intend to conduct our business in a different way. For example, the submissions we make as part of the budgetary process for the coming year will focus strongly on all the identified risks on our risk register, will have monetary figures attached to them and will be published. This is a watershed in that sense. It has to be. If we are going to be held accountable for political decisions and for the resources that are or are not available to us, as perhaps we should be, we are going to have to embrace that and take it forward in a responsible way.

I will set out what it will not mean. Sometimes this is presented in simplistic terms. It may be suggested that at various times in the past, the right thing to do would have been to withdraw a variety of services from Portlaoise. There is a real possibility that if this had been done, it would have made things much worse in macro terms, taking the entire population into account. We will have to be robust, but that does not mean we will be silly about it. The resources we have are the resources we have. As a result of the economic recovery, the resources we have now are better than the resources we had before. The health service is getting into a better place

in that sense. It is very clear that the judgment made in this report is that the HSE should have been much tougher about these things in the past. I think the only response to that is to be much tougher about them in the future.

Chairman: I thank Mr. O'Brien. I understand Dr. Crowley wants to make a final remark.

Dr. Philip Crowley: Deputy Regina Doherty expressed some concerns about my department. Rather than taking up more time, I will send the Chairman an update on what we are doing at present.

Chairman: I thank Dr. Crowley for that. In conclusion, I thank Mr. O'Brien, Dr. Henry, Professor Greene, Dr. Crowley, Dr. O'Reilly, Ms McGuinness, Mr. Woods and Ms Fitzgerald for their attendance, their co-operation and, as always, their courtesy. We have had a very long engagement with them. It is fair to say this meeting of the committee has been unique in so far as it has centred very much on the lives of people who have had a huge impact on committee members. I thank all the witnesses for being here this afternoon. It is important for this committee to reflect on the evidence it has heard before it does anything else.

The joint committee adjourned at 6.05 p.m. until 9.30 a.m. on Thursday, 28 May 2015.