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Irish inquiry reports relating to perinatal deaths and pregnancy loss services: What can we learn?

Inquiries in maternity services may be carried out if unexpected or recurrent adverse events occur. They aim to establish facts and ensure essential lessons are learned. In Ireland, there currently is no standardised method to the inquiry process, including the implementation of recommendations. To be effective and initiate positive changes in clinical services, national reports including inquiries need to include action plans with clear timelines and responsibilities. Inquiries are important to investigate rare, exceptional incidents of public concern, however they entail lengthy and complex processes. Affected families and staff should be included in these processes.

What is an Inquiry in Maternity Services?

In maternity services, unexpected, potentially preventable deaths or recurrent unexpected adverse outcomes may result in an inquiry being established to investigate events.

An external inquiry or review into specific adverse event(s) is instigated to examine matters of public concern.[1]

Ideally, the inquiry team, which will carry out the investigation, should be multidisciplinary, have relevant experience and be independent to the service under scrutiny.[1] Generally, inquiries involve the review of relevant medical files and documents, as well as statements or interviews with the appropriate staff and affected families.[1,2] A publicly-available report is published, including key findings and recommendations to address them.

Inquiries have multiple aims, including:

- Establishing facts or a timeline of events
- Holding professionals and organisations accountable
- Facilitating resolution
- Importantly, learning essential lessons to prevent events recurring.[1,2]

What did we do?

We conducted a study to better understand the relevance of external inquiries in maternity services.

Analyses of ten published inquiry reports (Table 1) related to Irish maternity services. These aimed to:

Compare reports:
- General structure
- Methodology
- Findings and recommendations.[3]

Identify standardised or variable inquiry procedures.

Highlight recurring report recommendations.[3]

Outline how developments in maternity services governance affected the Irish perinatal bereavement services.

Examine management of perinatal deaths (including events leading up to the deaths).[4]

What did we find?

Findings highlight a lack of standardisation of inquiry methods, review teams, timeframes and recommendation formation.

Report structure

- Only five reports (50%) explained the inquiry methodology used clearly.
- The reports varied from 11 to 210 pages in length.
- Lengthy reports are unlikely to be read in full. Having a comprehensive executive summary and recommendations section is essential.

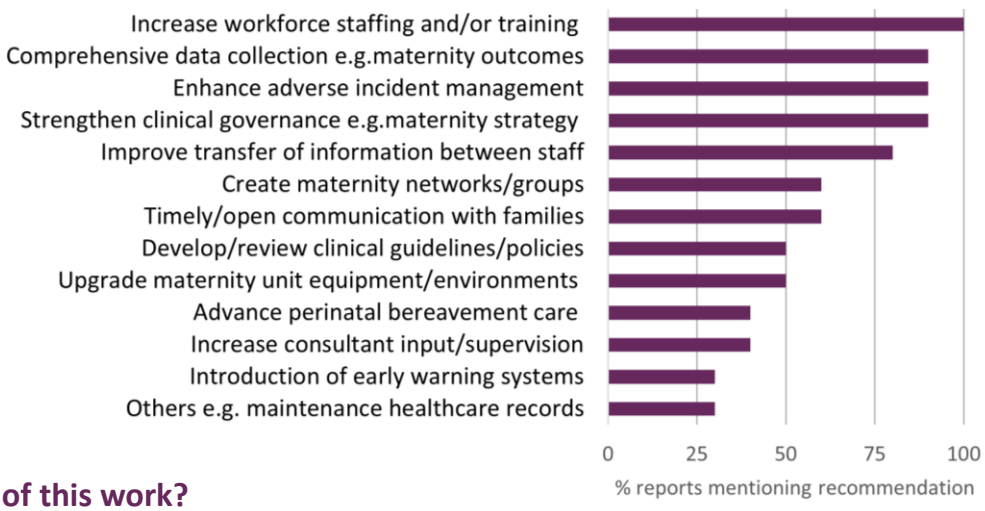
Inquiry process

- Seven of the inquiries (70%) were carried out by multidisciplinary teams, however, the selection process of these teams were not clearly outlined.
- There was inconsistent involvement of affected people (families as well as staff).

Issues identified with services and recommendations made

- Issues related to lack of leadership, workforce staffing levels, adequate infrastructures and effective risk management are still affecting the national maternity services.
- The number of recurring recommendations in the inquiry reports is concerning and suggests incomplete implementation (Figure 1).
- Outcomes of clinical care, including maternity care, should be monitored and improved according to agreed national standards.

Figure 1. Themes and frequency (%) of recommendations from the reports



Increasing the workforce staffing and training was recommended in all the inquiry reports.

What are the implications of this work?

- Ireland has a limited number of specialists in its maternity service; appointing experts to lengthy external inquiry processes reduces their time commitment to services already under pressure.
- Ongoing reliable internal adverse incident reviews may reduce the need for external inquiries, reserving their use for exceptional adverse events of public concern.
- A collaborative review process involving and supporting all persons affected, as well as including key stakeholders, is needed to ensure that all relevant issues are identified, and essential lessons are learned from each review and report.
- A standardised structure for inquiry methodologies and reports could be beneficial to this process and encourage completion of the investigation cycle.

References

[1]Buckley H, O'Nolan C. An Examination of Recommendations from Inquiries into Events in Families and Their Interactions with State Services, and Their Impact on Policy and Practice. Dublin; 2013. [2]Walshe K, Higgins J. The use and impact of inquiries in the NHS. Br Med J. 2002;325(7369):895-900. doi: 10.1136/bmj.325.7369.895. **[3]Helps Ä, Leitao S, O'Byrne L, Greene R, O'Donoghue K. Governance of maternity services: Effects on the management of perinatal deaths and bereavement services. Midwifery. 2021;101:103049. doi:10.1016/j.midw.2021.103049.** [4]**Helps Ä, Leitao S, O'Byrne L, Greene R, O'Donoghue K. Irish inquiry reports relating to perinatal deaths and pregnancy loss services. Ir Med J. 2020;113(2):P21.**

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