

**MINUTES OF THE BOARD MEETING OF  
THE HEALTH INFORMATION AND QUALITY AUTHORITY (The Authority)**

**Video Conference, Mahon and Smithfield  
22<sup>nd</sup> August 2013**

**Present:**

<b>Name</b>	<b>Details</b>	<b>Initials</b>
Brian McEnery	Chairperson	<b>BMcE</b>
Philip Caffrey	Board Member	<b>PC</b>
Sam McConkey	Board Member	<b>SMcC</b>
Grainne Tuke	Board Member	<b>GT</b>
Sheila O'Malley	Board Member	<b>SOM</b>
David Molony	Board Member	<b>DM</b>
Darragh O'Loughlin	Board Member	<b>DOL</b>
Una Geary	Board Member	<b>UG</b>
Anne Carrigy	Board Member	<b>AC</b>
Mo Flynn	Board Member	<b>MF</b>
Linda O'Shea Farren	Board Member	<b>LOSF</b>
Cillian Twomey	Board Member	<b>CT</b>

**In Attendance:**

Tracey Cooper	Chief Executive Officer	<b>TC</b>
Kathleen Lombard	Board Secretary & Chief Risk Officer	<b>KL</b>
Phelim Quinn	Director of Regulation	<b>PQ</b>
Mary Dunnion	Deputy Director of Regulation	<b>MD</b>
Judy Gannon	Project Officer	<b>JG</b>
Margaret Cahill	QA Manager	<b>MC</b>
Anne O'Connell	Directorate Business Co-ordinator	<b>AOC</b>
Gillian Hastings	Programme Co-ordinator	<b>GH</b>
Kelly Jones	Administrative Assistant	<b>KJ</b>
Richard O'Sullivan	Legal Adviser	<b>ROS</b>
Marie Kehoe O'Sullivan	Director of Safety and Quality Improvement	<b>MKOS</b>
Marty Whelan	Head of Communications	<b>MW</b>

**1. Quorum**

It was noted that a quorum was present and the Board meeting was duly convened. BMcE stated that the purpose of the meeting was to consider the draft Investigation Report into the *Safety, Quality and Standards of Services provided by the HSE to patients, including pregnant women, at risk of clinical deterioration and as reflected in the care and treatment provided to Savita Hallapanavar at University Hospital Galway.*

## **2. Conflict of interest**

UG stated that she, as Clinical Lead for the National Emergency Medicine Programme, could be perceived as having a conflict of interest if a discussion arose in relation to clinical programmes. If such a discussion did arise she would absent herself from the meeting.

DMcL noted that he is aware that a neighbour of his has been interviewed during the investigation. It was considered that this did not constitute a conflict of interest.

## **3. Purpose of the meeting**

TC advised the Board that the purpose of the meeting is to

- Seek and receive assurance from the Executive that the investigation has been conducted in accordance with the terms of reference agreed by the Board and is in compliance with the Authority's internal investigative processes and
- to receive the draft report for information and discussion prior to it being circulated for factual accuracy.

TC reminded all those present of the confidentiality of proceedings and that documentation will be collected from attendees at the end of the meeting.

## **4. Presentation on the Investigation process**

MD, Deputy Director of Regulation, presented to the Board on the Investigation Assurance Mechanisms. This included how the Authority's Monitoring Approach (AMA) was applied to the Investigation, how and where the terms of reference are captured in the draft report and how the investigation follows lines of enquiry that are aligned with the themes in the National Standards for Safer Better Healthcare.

## **5. Presentation on the Investigation findings**

PQ (Director of Regulation) outlined to the Board the key findings of the draft report in the areas of the care provided to Savita Hallapanaver; clinically deteriorating pregnant women; clinically deteriorating general adult patients; and maternity services at UHG and nationally.

## **6. Discussion on the report**

Following the presentations, the Board discussed the report at length and sought clarifications on aspects of the process and the events and findings of the draft investigation. The following points were noted:

- Areas where clarifications on the events and findings were sought by the Board needs to be clarified in the final report
- The findings need to stand out clearly and are plainly linked to the evidence so the report will need to be crisper in places
- The report must be an agent for change and therefore communication and follow up on the report following publication is essential
- The recommendations will have a national scope so that all maternity services adopt a standard approach.

## **7. Next steps**

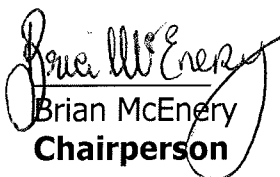
TC outlined the next steps in the investigation process including

- That clarification on the points raised will be provided where necessary in the report
- The investigation team will be meeting on August 27<sup>th</sup> to agree any remaining points
- Extracts of the report will be issued to relevant parties as part of the factual accuracy process
- Responses to this process will be considered and reflected in the final draft where appropriate
- The Board will meet again when the report is finalised to consider it for approval.

## **8. Any other Business**

TC advised the Board that the Authority has been invited to present on its current work to the Oireachtas Health Committee on September 12<sup>th</sup>.

**Signed:**

  
Brian McEnery  
**Chairperson**

  
Kathleen Lombard  
**Board Secretary**

