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

Video Conference
7th October 2013

Present:

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

In Attendance:

Tracey Cooper	Chief Executive Officer	**TC**
Kathleen Lombard	Board Secretary & Chief Risk Officer	**KL**
Phelim Quinn	Director of Regulation	**PQ**
Judy Gannon	Project Officer	**JG**
Hilary Coates		
Anne O'Connell	Directorate Business Co-ordinator	**AOC**
Gillian Hastings	Programme Co-ordinator	**GH**
Kelly Jones	Administrative Assistant	**KJ**
Marie Kehoe O'Sullivan	Director of Safety and Quality Improvement	**MKOS**
Marty Whelan	Head of Communications	**MW**
Niall Michel	Lawyer, Mason hayes and Curran	**NM**

Mairin Ryan also in attendance KL 20/11/13

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 final 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.* While the Board had considered an earlier draft, prior to the factual accuracy process, the purpose of the meeting was to finalise their deliberations and approve the report if appropriate.

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.

3. Investigation Update

GH presented to the Board outlining which parts of the report related to the terms of reference for the investigation. She also updated the Board on the main activities that took place since the Board met to consider the draft report in August which included the factual accuracy process. Following this process, all feedback was analysed, cross referenced with the investigation findings and where appropriate and relevant, this was reflected in the final draft report. Legal input had also been sought in relation to the report.

The key findings of the report and the associated recommendations were also presented to the Board.

The Board discussed the report and the following points were considered in detail:

- The central factor in this case was failure to recognise, and act upon, the clinical deterioration of the patient and the failure to manage sepsis
- The duties and responsibilities of organisations to act upon such incidents and circumstances, including the referral of healthcare professionals, where appropriate, to relevant professional regulatory bodies
- That there were a number of inconsistencies in the terminology in the report which need to be addressed/clarified
- That the failure of the system to learn from similar events, such as those outlined in the HSE enquiry of the death of Tania McCabe report is a further concerning factor.

Following discussion and clarification on the report, the Board complimented the Executive on the quality of the report and agreed that it should be approved. AC proposed that the 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* be approved and DOL seconded the proposal; **accordingly the 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 was approved by the Board.***

4. Next steps

TC outlined the next steps in the process, explained that there will be some additional edits to address the inconsistent/unclear terminology and clarity of emphasis identified by the Board. Following this exercise, copies of the report will

be issued to key stakeholders and briefings will be provided to them also, after which the report will be published.

The Chairperson expressed his thanks to the Board members for considering the report so closely and to Investigation team for the high quality of work that had culminated in an excellent report that will have an important impact on future healthcare services.

8. Any other Business
There being no further business, the meeting was closed.

Signed:

Brian McEnery
Chairperson

Kathleen Lombard
Board Secretary