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Characteristics of serious incident management team (SIMT) reviews in maternity units

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Abstract

Aim

This study analysed the current local Serious Incident Management Team (SIMT) perinatal death review processes in Irish maternity units in two different years and compared the results.

Methods

Quantitative and qualitative data on SIMT reviews were collected via an electronic questionnaire. Members (2-3) of the management teams in 19 Irish maternity units were asked to participate (January-July 2019 and May-August 2023). The characteristics of SIMT processes (cases reviewed, members, timeframe, parents' involvement) in the different units were analysed.

Results

There was little consensus across the units regarding which cases were reviewed, composition of the SIMT and the timeline of reviews. Consultant neonatologists, consultant anaesthesiologists and doctors-in-training were underrepresented at SIMT meetings. 4 units (22%) and 6 units (38%) stated that reviews took >6 months to be completed in 2019 and 2023 respectively. Parents were informed about the review inconsistently, with 11 units (58%) informing parents "frequently" and 8 units (50%) "always" informing parents about the review in 2019 and 2023 respectively.

Discussion

Perinatal death reviews are not standardised in Irish maternity units. A nationally co-ordinated system would ensure that all perinatal death reviews are of the same standard, with SIMTs following an agreed timeframe and producing comparable reports with

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implementable recommendations. Delays in reviews and report dissemination result in long wait times for answers for bereaved parents and prevents local learning opportunities.

Introduction

Pregnancy is a natural physiological process, and outcomes are generally expected to be positive. While there are many minor pregnancy complications that can occur, outcomes such as unexpected term perinatal deaths (stillbirths and neonatal deaths) are uncommon and devastating. It is imperative that these events are appropriately investigated, the bereaved families are fully informed and, if indicated, changes in maternity care are made.

Incident reviews in health care, such as mortality reviews, are carried out to establish what happened, how and why an adverse outcome occurred[1]. Local mortality reviews aim to identify any modifiable contributory factors, and to prevent recurrences of events if possible. There is consensus that review teams should be multidisciplinary to allow identification of all contributory risk factors and optimise learning[2–5]. Administrative support is important to arrange local meetings and take minutes, thereby maximising time spent on discussing cases[2]. A thorough local incident review requires significant time and resources[2].

The World Health Organization (WHO) published a comprehensive perinatal death review guide in 2016 (Making every baby count: audit and review of stillbirths and neonatal deaths), which outlined how to "review selected individual cases for systematic, critical analysis of the quality of care received, in a no-blame, interdisciplinary setting"[4]. This was followed by the publication of a guideline from the WHO in 2021 to support implementation of perinatal death reviews[6]. To reduce the number of term birth-related perinatal deaths and brain-injuries (encephalopathy) in the United Kingdom (UK) the Royal College of Obstetricians and Gynaecologists commenced the quality improvement programme "Each Baby Counts" (EBC) in 2014, which concluded in 2018[7]. This programme showed that midwives (97%) and obstetricians (97%) were most commonly present for local reviews in 2018, however senior management was involved in only half of reviews[8]. The final report from EBC demonstrated that a range of review methodologies were used to review perinatal deaths[9]. Separately, the Perinatal Mortality Review Tool (PMRT-UK) has been used within the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) programme since 2017 to standardise local reviews across the UK[5].

In the Netherlands, nationwide perinatal audits were set up in 2010; local cases were reviewed systematically by a multidisciplinary team (including an external chairperson) to identify contributory factors and make recommendations to improve quality of care[10]. A 2016 law in the Netherlands mandated the submission of investigation reports to the national regulatory body within 8 weeks of the incident, to ensure a timely local review occurs for all

incidents that have caused serious harm or death[11]. Furthermore, Dutch hospitals are mandated to involve families in all incident investigations since 2016[11].

In 2022, there were 290 perinatal deaths (all stillbirths and neonatal deaths >24 weeks gestation and/or weighing >500g) reported in Ireland that were not due to termination of pregnancy[12]. The Irish Health Service Executive (HSE) recommended that a Serious Incident Management Team (SIMT) to be established in all hospitals to review serious reportable events (SREs) locally. From 2015, all perinatal deaths of infants >37 weeks gestation and/or weighing >2,500g were considered SREs[13]. The Irish National Incident Management Framework (NIMF) was published by the HSE in 2018 and updated in 2020[14]. It states that any serious incident should be reported within one working day and discussed at the SIMT meeting to decide the review level and approach to be taken[14]. It is advised that the review should be completed within 125 days of the incident occurring[14]. These requirements were further enshrined in national legislation with the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, which stipulates the mandatory reporting of notifiable incidents (including perinatal deaths), and mandates open disclosure to the affected families following notifiable incidents[15].

Perinatal death reviews are important to identify modifiable factors, to recognise weaknesses in healthcare services and to provide learning opportunities, thus prevent future deaths, if possible[3,6,16]. Furthermore, these reviews are an important part in promoting and ensuring continuous quality improvement in maternity services[16].

The aim of this study was to analyse the status of SIMT perinatal death review processes in the 19 Irish maternity units in 2023 and compare these findings to the SIMT process in 2019.

Methods

In 2019, a service evaluation of the local SIMT perinatal death reviews in Ireland was conducted using an electronic survey. The survey contained 31 questions regarding SIMT processes, parental involvement in reviews and personal professional practice. In 2023 the survey was updated to include more detailed questions (58 in total) about SIMT processes and parent involvement. The sections of the surveys are outlined in Table 1. The surveys were sent to the management team (including the clinical director, director of midwifery, general manager, lead obstetrician and/or lead neonatologist as indicated) of all 19 maternity units in 2019 and 2023. Two to three individuals were asked to participate in each of the units. Data collection took place during two separate periods: period A (January-July 2019) and period B (May-July 2023). To ensure data representativeness, one final data collection wave was completed in January 2024 with responses (related to 2023) from two additional units included.

The varying characteristics of SIMT meetings in the different maternity hospitals nationally were analysed using descriptive statistics to outline type of cases reviewed, members of the review team, timeframe of the reviews, dissemination of the final report, and bereaved parents' involvement. Results from the two different years of data collection were compared to study any evolutions or changes nationally since publication of the NIMF. Findings were also discussed in line with the standards outlined in the NIMF. Participants were asked to share their views on the local review meetings. These free text answers were grouped into positive, mixed and negative comments with a frequency count.

The study was approved by Clinical Research Ethics Committee of the Cork Teaching Hospitals [No: ECM 4 (q) 16/10/18, ECM 3 (ddd) 06/11/18 and ECM 4 (e) 28/03/2023, ECM 3 (sss) 09/05/2023].

Results

In total we received 25 responses (22 completed questionnaires, 3 partially completed) from the 19 maternity hospitals in 2019, and 29 (28 completed, 1 partially completed) from 17 maternity units in 2023. Responses were grouped and cross-checked by hospital to examine potential conflicting answers within the same hospital. If there were multiple conflicting answers from one unit, the most common answer was selected. In 2019, 22 individuals responded to the free text section of the survey regarding their personal views of local reviews and 24 individuals responded to this section in 2023.

Type of cases reviewed

Twelve of 17 hospitals reported that they discussed cases of encephalopathy, intrapartum deaths (the death of a baby during labour) and perinatal deaths at the SIMT meetings in 2019. In 2023, 13 of 15 units stated they discussed perinatal deaths (defined as stillbirths, early and late neonatal deaths) and encephalopathy cases at the SIMT meetings. For one hospital in 2019 and two hospitals in 2023 conflicting answers were recorded.

Members of the SIMT

In 2019, 16 (84%) of the 19 Irish maternity units reported having their own SIMT. Two further units reviewed their cases in the hospital-group SIMT, and one unit was incorporated into the co-located general hospital SIMT. Only three units (17%) reported "frequently" seeking expert external input into the local reviews and 13 (72%) sought this input "sometimes" in 2019.

In 2023, 12 (71%) stated that their SIMT meetings were organised at both hospital and hospital-group level. Four units organised their SIMT at hospital level only and one at hospital-

group level only. In 2023, the SIMT meetings were chaired by the hospital manager in 8 units, the QPS manager in 4 units, a consultant in obstetrics and gynaecology in 2 units, and the director of midwifery in 1 unit, with one unit giving a mixed response. In 2023, three units (19%) sought external input for every case and 10 units (63%) reported seeking this less than 50% of the time.

Consultant neonatologists and anaesthetists were underrepresented at SIMT meetings, though their attendance did improve between 2019 and 2023 (figure 1). Doctors-in-training were also underrepresented at SIMT meetings, with only one unit indicating their presence at SIMT in 2019, increasing to four units in 2023.

Timeframe of the SIMT reviews

The timeframe of SIMT meetings and reviews varied considerably between, and at times within, units (Figure 2). Timeframes varied depending on the type and complexity of the incident. Four units (22%) in 2019 and six units (38%) in 2023 stated that reports were published more than 6 months (> 26 weeks) after the incident occurred (Figure 2).

Dissemination of the final report

Generally, most reports were submitted to management personnel in both 2019 (16/18 units) and 2023 (14/16 units). In 2019 the final review reports were provided to service users/families in 33% of units (6/18 units), whereas in 2023 this was done in 44% of units (7/16 units). Twelve units (66%) submitted reports to multiple recipients (e.g. local management and stakeholders or local quality/patient safety personnel) in 2019, this had increased to 94% (15/16) in 2023.

Bereaved parents' involvement

In 2019, the bereaved parents were informed of the review "frequently" in 11 units (58%), "sometimes" in 4 units (24%) and "rarely" in one (6%). In 2023, more detailed questions regarding parent involvement were included in the survey. Of 16 units that provided data, bereaved parents were consistently informed of the review in 8 units (50%), some of the time in 4 units (25%), two units provided conflicting answers, and one unit did not know if parents were informed. Parents were invited to be involved in the review process: always in 6 units (40%), more than half the time in 4 units (27%), less than half the time in 2 units (13%) and never in 3 units (20%); one unit did not respond to the question. Parents were invited to provide feedback for inclusion in the SIMT always in 6 units (37%), some of the time in 3 units (18%), never in 4 units (25%), with 3 units providing conflicting answers.

Participants' views on the reviews

Twenty respondents in 2019 and 15 individuals in 2023 gave comments on their own personal involvement in the local perinatal death review process and their views and opinions on this

(Box 1). Most participants (91%, n=20/22 in 2019; 95%, n=19/20 in 2023) found these meetings relevant to their personal clinical practice. The workload was described as significant, including the identification, preparing, and coordinating of cases/documents. While some felt the current process was comprehensive, lacking resources were highlighted as a concern. This, as well as the time commitment required, were described to add delays in completing the reviews in a timely manner.

It was noted that learning opportunities arise from the reviews, however at times these were not well disseminated or changes in clinical services not noticeable (Box 1). One person mentioned that implementing recommendations from the reviews was "often challenging".

Three (in 2019) and two (in 2023) individuals described the involvement in the review process as "stressful" for clinical staff; the importance of supporting, as well as debriefing staff, was appreciated. Initiatives implemented to support staff after an event or during the review (e.g. After Action Reviews) were mentioned by three participants in 2019. While comments were limited in 2023, five individuals in 2019 described meeting and debriefing bereaved parents as part of their role, sometimes more than once during the review process.

Discussion

Our study showed that all 19 Irish maternity units discussed serious incidents at SIMT meetings, in line with the NIMF. However, despite this framework, there was little consensus across the 19 units regarding which cases were reviewed, who were the participating members of the SIMT and the timeline of reviews from incident to completed report. These findings did not change significantly between the 2019 and 2023 surveys, despite updated guidance from the NIMF in 2020. By comparing our findings to examples from the international literature, we discuss how these processes can be standardised at a national level.

Perinatal mortality reviews can help to identify modifiable factors in perinatal deaths. Identifying and learning from these factors may highlight changes required to improve the quality of clinical care, with the aim of reducing further perinatal deaths[6,17]. The structure of the perinatal mortality review team is an important part of the review process[6,14]. The SIMT should include "nominated members of the executive management team, including the clinical director, director of nursing or midwifery and the quality and patient safety advisor" and any other relevant professionals with expertise relating to the incident as necessary[14].

In our study, 93% of SIMT groups included hospital management as members in 2019. With updated guidance on structuring SIMTs from the NIMF in 2020, it is unsurprising that all units that responded to the survey in 2023 included senior management and QPS advisors as part of their SIMT team. The NIMF advises that a Senior Accountable Officer (SAO) is responsible

for chairing and overseeing the SIMT when an incident occurs, and this study demonstrated that in 2023 the SAO in most cases was a member of hospital management or a senior clinician. When the SIMT was reported as being chaired by a consultant, it was not clear if this individual had specific expertise in reviews. Previous research has highlighted that each member of the review team should have a defined role; either as an expert in their field or in investigation methods, or as part of management to create relevant learning opportunities[18]. It is notable that consultant neonatologists or paediatricians, consultant anaesthetists and doctors-in-training remain underrepresented at SIMT meetings in 2023. This finding is similar to the UK-PMRT reviews, where neonatologists, neonatal nurse specialists and members of risk management were also underrepresented at reviews[19].

An external reviewer can provide unbiased opinions on the clinical care provided, including constructive criticism without blaming individuals[20]. Our study highlights that expert external input is not routinely sought for local SIMT reviews in most Irish maternity units and this did not change between 2019 and 2023. Low consultant numbers may have resulted previously in difficulty recruiting external reviewers in Irish maternity units, as this commitment impacts a consultant's clinical schedule. One individual in the study commented how their unit "struggles with expert external investigations due to the expertise and time commitment required". Other studies have also demonstrated that external review panels are costly and labour intensive[16,20]. However, significant expansion of consultant numbers in Ireland in the last ten years (from 174 in 2019 to 204 consultants in obstetrics and gynaecology in 2023) provides more opportunity for consultants to be involved in external reviews for other units, which is considered part of a consultant's role[21,22].

SIMT meetings are comprised of staff members who often don't have specifically allocated time to participate in reviews. It has been recommended that clinical experts have allocated time included in job plans to participate in reviews[5,6]. Lack of protected time for participation in reviews along with lack of administrative support for review teams may contribute towards delays in completing reviews. Administrative staff complete time-consuming but important tasks (e.g. gathering documentation, timely responses) essential for the adequate running of the review process[2]. The WHO guide states that "supportive administrators and health professionals can make all the difference between success and failure" of perinatal mortality reviews[4].

The review report of a perinatal death is one of the most important aspects of the review process, allowing SIMT teams to share findings and highlight actionable changes[6]. The WHO guidance and the NIMF emphasise the importance of shared learning by dissemination of findings and recommendations[6,14]. The NIMF advises sharing lessons learned from reviews with the quality and safety committee in the hospital[14]. A "learning summary" can be shared locally with staff members to highlight learning from a review[14]. While dissemination of review reports improved between 2019 and 2023 within units (likely reflective of the updated

NIMF), the learning and recommendations that come from the reports is not shared effectively between units or at national levels in Ireland. There are efforts underway nationally to change this with the establishment of the Obstetric Event Support Team (OEST) in 2021, which is part of the National Women and Infant Health Programme (NWIHP)[23]. The OEST, which acts at a national level in Irish maternity units, primarily aims to improve the learning from adverse events while providing support locally. There have not yet been any published findings from the OEST involvement in obstetric events. The PMRT system in the UK is an example of a collaborative shared learning programme at national level. A report is published annually with the collated findings from perinatal death reviews in the NHS[24]. Targeted programmes, including the PMRT programme, have helped to develop a sustained reduction in the perinatal mortality rates in the UK over time[9,24,25].

The WHO guide recommends that perinatal deaths are reviewed within one week of the event[4]. In Ireland, the timeframe advised by the NIMF from incident notification to submission of the final report to the review commissioner is a maximum of 125 calendar days (18 weeks)[14]. Despite this, there is currently no consensus across the maternity units about how long serious incident reviews take, with 22% of units requiring more than 26 weeks in 2019. This timeframe appeared to worsen over time with 38% of units in 2023 publishing a report 26 weeks after the event occurred. The Coroner's (Amendment) Act 2019 significantly expanded on the type and number of perinatal deaths that are referred to the Coroner for investigation[26]. Waiting on a Coronial post-mortem report to include in the final review report may be contributing to the lengthening publishing times. A delay in reviewing events and report dissemination means a long wait for answers and closure for both the affected families and staff. Conversely, with the short-commanded timeframe of 8 weeks to complete local reviews in the Netherlands, Kok et al noted difficulties with involving families appropriately amid their bereavement and practical needs[11].

Currently it is not standard practice to involve bereaved parents in the local review process in all Irish maternity units. Our findings suggest that families are not consistently at the centre of reviews into their cases, and this has been demonstrated in other perinatal death review processes internationally[27,28]. Other studies have demonstrated that parents may find the review process difficult to understand or confusing and, in some cases, they may not be aware that a review of the death of their baby is taking place[29,30].

While bereaved parents are usually debriefed after the review is completed to offer them the key findings, our study showed that the final review report was physically provided to the parents in less than half of cases, which did not change between 2019 and 2023. The NIMF recommends that the final report is provided to the affected person or their family in a supportive manner ideally in person[14]. They advise that a designated liaison person is assigned to the family to ensure they are kept informed and have a point of contact with the hospital.

Perinatal death reviews may provide answers to bereaved parents regarding the cause of death and identify important information to help plan for future pregnancies[3]. Additionally, the review process may help them to process the death of their baby. Parents have reported that they would like to be involved in the review of their baby's death, and research has demonstrated that parental involvement in death reviews helps to improve the process for other parents as well as for staff members[31]. Parent involvement may also help to restore trust in the health service and avoid complaints[11]. Additionally, early and sustained engagement with families following an SRE may help to reduce rates of litigation, which have increased exponentially in recent years[32].

Findings and recommendations from local reviews can be valuable to the families, the maternity unit, as well as the staff involved in a perinatal death. However, perinatal death reviews can have a considerable toll on the staff who were involved in the family's care[33]. This is especially influenced by an organisation's underlying culture towards incident reporting and reviews[34]. The cultural element of an institution was raised in several comments from respondents, with some commenting on the "stress" caused for staff involved in reviews, and another respondent mentioned the importance of a "just culture" when it comes to incident management. A strong blame culture, poor engagement with management and inadequate feedback to staff following a review may result in significant emotional distress for staff, under-reporting of contributory factors and lack of trust in hospital leadership[6,35].

It is worth noting that the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 legislation came into effect in September 2024, which was after the surveys in the study were conducted[15]. The act requires mandatory reporting to the relevant regulatory bodies of all perinatal deaths >37 weeks' gestation and/or babies weighing >2,500g[15]. It also mandates open disclosure by the health services provider about the notifiable incident to the patient and/or their family. The act specifies that a designated liaison person should be assigned to liaise between the patient (or their family) and the health services provider[15]. This legislation will effectively strengthen the open disclosure process between hospitals and patients/families following a notifiable incident, such as a perinatal death.

This study focussed on the maternity units in Ireland, gathering self-reported information from 1-3 managers on the local SIMT review process and its main benefits and challenges. As the surveys were completed by staff members in various roles, it is possible that the answers given did not fully capture all aspects of the SIMT process in each unit. Further research is required to examine the challenges of implementing review recommendations, monitoring improvements to clinical care, and the involvement of bereaved parents in reviews.

There is no standardised process for conducting perinatal death reviews within the SIMT structure in Irish maternity units. A significant challenge to completing reviews in a timely and comprehensive fashion is a lack of resources, both in relation to staff and time. Additionally, external experts were underrepresented at review meetings. It is essential to promote parents' involvement in reviews; it allows them to give important clinical feedback, receive answers to questions regarding their clinical care while potentially restoring trust and confidence in the services.

To complete comprehensive reviews, the multidisciplinary review team needs to have the appropriate resources available, including protected time, managerial and administrative support. Additionally, consideration should be given to appropriate training for staff who are participating in reviews. A nationally co-ordinated system using a standard format would help to ensure that all local perinatal death reviews in Ireland are of the same standard and follow the same structure. It is important that multidisciplinary review teams adhere to an agreed timeframe and produce comparable reports with recommendations that are implemented.

Declarations of Conflicts of Interest:

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Section	Questions regarding:
Name of Maternity Hospital	
Serious Incident Management Team (SIMT) Reviews	Local SIMT Members of SIMT Timeframe of review Report submission Type of cases reviewed External input Bereaved parents' involvement
Perinatal Mortality Multidisciplinary Team (MDT) Meeting	Perinatal mortality MDT structure Timeframe of perinatal mortality MDT
Professional practice	Personal views and opinion of review processes

Table 1: Sections and focus of the questions included in the survey.

Fig. 1 Members of the SIMT in the maternity units

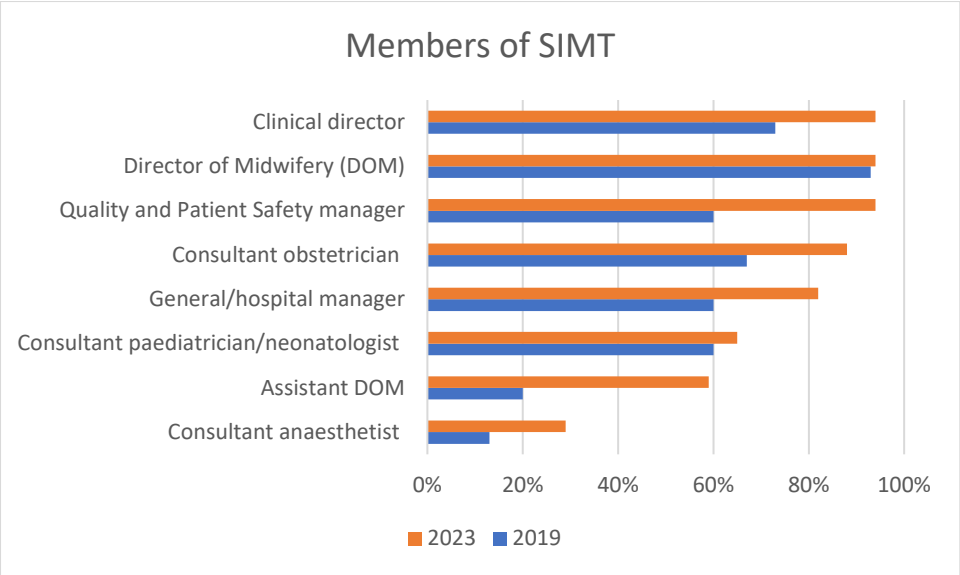
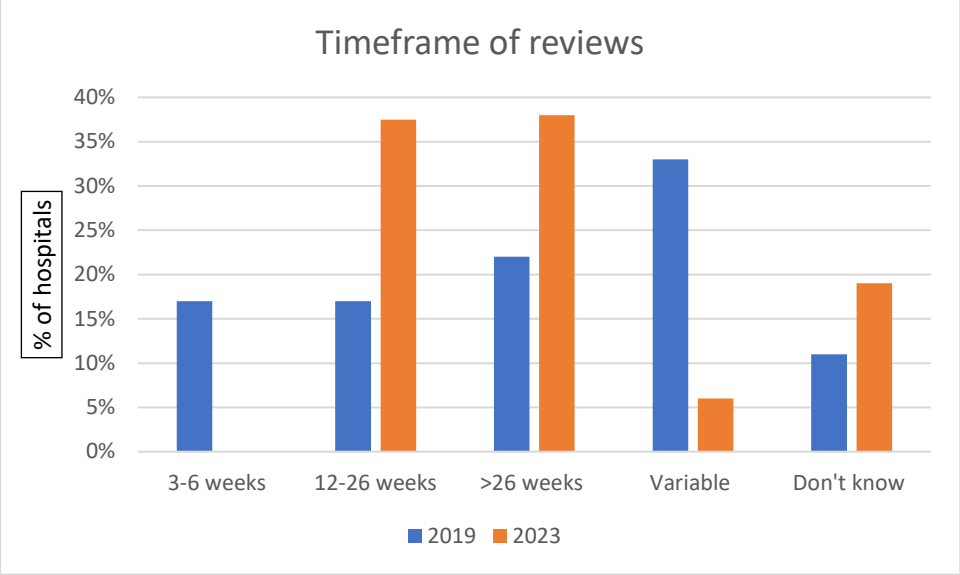


Fig. 2 Timeframe of SIMT reviews in the maternity units



Box 1: Personal opinions on the local perinatal death reviews.

Positive

"We (Clinical Risk Managers) are involved in all SIMT reviews. We coordinate the Clinical Incident Review Group meetings where all priority incidents are reviewed by a multidisciplinary team and attend the Perinatal M&M discussion group meetings. The hospital name review process is evolving and continually reviewed and updated in accordance with national requirements and is currently working well." (Response 4, 2019)

"As Assistant Director of Midwifery I am involved in most of the Case reviews and invited to SIMT Meetings. It is my opinion theses forums are open and transparent in their fact finding process. I am of the opinion these meetings occur in the recommended timeframe." (Response 11, 2023)

Mixed

"I take a very keen interest into the care processes that are afforded to the families. I would be involved in the debriefing of some of the families. While the review process can be extremely long and time consuming it is so worthwhile to support the families in their grieving process and dealing with that loss of a life. Professionally I feel that the reviews need to be

opened up to all staff for them to review so that the impact of findings whether good or bad can have a more widespread effect." (Response 18, 2019)

"I feel it is a valuable process, difficult as it can be sometimes however, it can highlight clinical issues but also good practices. The actually process of writing up a review report is extremely time consuming and while it effects all the individuals involved with a specific case I'm not totally convinced that it changes the practices of others unless they have been directly affected. I think human factors get involved, particularly complacency within practice for some individuals especially if there is no impetus to improve or develop compliance with standards on an individual basis rather than an organisational one. e.g. 'that is someone else's job' " (Response 6, 2019)

“They are a significant workload. They are stressful for the staff involved which has an impact on staff morale and retention of staff. The process of incident reviews has been comprehensive and robust. The quality of the recommendations is variable and often challenging to implement. There have been improvements in the quality of service provided arising from some reviews but there is a large emphasis on what has gone wrong within the department rather than what is being done well.” (Response 12, 2019)

“A just culture with incident management is essential for psychological safety of staff.” (Response 3, 2023)

Negative

“The current review process as outlined in the HSE guidelines is incredibly cumbersome, time consuming and not particularly fit for purpose. It results in lengthy and unacceptable delays for parents and staff. It requires streamlining and a practical approach to be rolled out and adopted nationally to ensure consistency of process and outcomes. It relies on busy staff to undertake the reviews and often staff who have been involved in one don't want to undertake another as they've taken up huge amounts of time, with little resources.” (Response 16, 2019)

“Time is always a factor, in busy clinical roles, staff are doing their best to take the time and give input but there is never enough time. It can also be extremely stressful for staff.” (Response 6, 2023)

“Have been involved as a member of the review team. Long process, difficult for parents and staff. Still very adversarial.” (Response 2, 2023)