2026-28

REPLY BY THE PRESIDENT OF
THE COMMITTEE FOR HEALTH & SOCIAL CARE
TO QUESTIONS POSED BY DEPUTY GAVIN ST. PIER PURSUANT TO RULE 14 OF THE RULES OF PROCEDURE

Question

In August 2015, Dr Elaine Maxwell submitted her final report, entitled "An organisational review following the serious maternity incident in January 2014..." The report contained 12 recommendations.

Could the Committee please tabulate what action, if any, it has taken in response to each recommendation?

Answer

The report referred to is more than a decade old and relates to a sensitive case involving confidential clinical matters. The Committee is therefore unable to provide a recommendation-by-recommendation account of actions taken in response to the report.

An action plan was developed following the review and its recommendations were addressed through a programme of improvements to governance, clinical leadership, staffing, policies, training, incident management and patient safety processes.

The Department's own action plan from 2015 demonstrates that work was initiated across all 12 recommendations and an update provided to the then Committee in 2017 confirms that all actions were completed. The Committee acknowledges that following this deeply regrettable case a range of reviews, stemming from the action plan, highlighted areas requiring improvement and identified important lessons that informed the programme of service development and quality improvement that followed.

Since that time, maternity services have undergone significant further development and have continued to evolve in line with UK standards, national guidance and subsequent reviews. The Nursing and Midwifery Council revisited Guernsey in 2016 and confirmed that major improvements had been made and that no further monitoring visits were required. In addition, substantial investment was made in staffing and service provision, including additional consultant obstetricians, increased midwifery capacity and enhanced clinical leadership arrangements.

The Committee is satisfied that the findings of the 2015 review have long since been overtaken by subsequent service improvements, national standards and ongoing quality assurance processes. Maternity services continue to benchmark themselves against relevant national reviews and best practice, adopting recommendations locally where appropriate.

Ends.