Tús Áite do Shábháilteacht Othar
Patient Safety First

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

QUALITY & PATIENT SAFETY AUDIT
FINAL AUDIT REPORT – EXECUTIVE SUMMARY

Audit Title:	**Audit of the compliance of the notification and investigation of incidents of sudden, unexplained death in approved centres with legislative requirements and HSE policy and procedures**		
Audit Number:	QPSA 001/2013		
Audit Timeframe:	March – May 2013		
Audit Requester:	1) Mr Martin Rogan, HSE Assistant National Director, Mental Health 2) Ms Maria Lordan Dunphy, HSE Assistant National Director, Integrated Services Directorate and Co Chair HSE National Incident Management Team 3) Ms Cora McCaughan, HSE Quality and Patient Safety Directorate and Co Chair HSE National Incident Management Team		
Audit Team Members:	1) Ms Ciara Murray (Lead Auditor)		
	2) Ms Jo O'Rourke		
Audit Sponsor:	Ms. Edwina Dunne – HSE Director of Quality & Patient Safety Audit		
Source of Evidence	**Type**	**Location**	**Date of issue**
	Desktop audit - request for evidence issued to 17 approved centres	**Approved centres (date of issue of request for evidence):** **HSE Dublin North East** Department of Psychiatry, Cavan General Hospital (04 March 2013) Department of Psychiatry, Our Lady's Hospital, Navan (04 March 2013) Department of Psychiatry, Connolly Hospital, Blanchardstown (11 March 2013) St Brendan's Hospital - Grangegorman, Dublin 7 (11 March 2013) St Vincent's Hospital - Fairview, Dublin 3 (11 March 2013) **HSE Dublin Mid Leinster** Acute Psychiatric Unit, AMNCH (Tallaght) (04 March 2013) Newcastle Hospital, Co. Wicklow (04 March 2013) Department of Psychiatry, Midland Regional Hospital, Portlaoise (05 March 2013) **HSE South** Department of Psychiatry, St Luke's Hospital, Kilkenny (04 March 2013) Department of Psychiatry, Waterford Regional Hospital (04 March 2013) St Senan's Hospital, Enniscorthy, Co Wexford (04 March 2013) St Stephen's Hospital – Cork (05 March 2013) **HSE West** Acute Psychiatric Unit, Midwestern Regional Hospital, Limerick (04 March 2013) Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis (04 March 2013) Adult Mental Health Unit, Mayo General Hospital (04 March 2013) Department of Psychiatry, University Hospital Galway (04 March 2013) Sligo/Leitrim Mental Health In-patient Unit (04 March 2013)	
Issue of Final Report:	15 May 2013		

1. AUDIT BACKGROUND/RATIONALE

For the years 2010 and 2011 there were approximately 31 incidents of sudden, unexplained death[1] in approved centres[2] across the country.

When a death of this nature takes place there are a number of statutory obligations on the manager of the approved centre to notify and investigate the incident. For instance, Article 14 (4) of the Mental Health Act 2001 (Approved Centres) Regulations 2006 states:

14. Care of the Dying

(4) The registered proprietor shall ensure that the Mental Health Commission (MHC) is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.'

The Inspector of Mental Health Services examines all death notifications and in cases suggestive of suicide or violent death requests that a review is carried out by the service and a copy sent to him.

Other external agencies requiring notification of an incident of sudden, unexplained death include the Clinical Indemnity Scheme (CIS), the coroner and the Gardaí Síochána.

These requirements are supported by the HSE Incident Management Policy and Procedure (HSE, September 2008) document which stipulates that all incidents should be reported to the designated person locally as well as the relevant statutory bodies (where appropriate) and should be investigated using the recommended systems analysis approach to investigation.

Integral to the systems analysis approach is the systematic identification of causes/contributory factors of incidents with the concomitant identification of appropriate recommendations and learning points. A guidance document was developed by the HSE in March 2009 to support managers in conducting investigations of this type (Toolkit of Documentation to Support HSE Incident Management).

In order to gain a better understanding of the risks associated with sudden, unexplained deaths the National Office for Mental Health in conjunction with the Integrated Services Directorate (ISD) and the Quality Patient Safety Directorate (QPSD), as a first step, has determined that an audit of the quality of investigations and associated reports is required. Standardised reports conducted in accordance with HSE guidance are essential if opportunities for improvement in patient safety are to be identified and acted upon.

2. AUDIT OBJECTIVES

The objective of the audit is to determine if incidents of sudden, unexplained death in approved centres are notified and investigated in accordance with legislative requirements and HSE polices and procedures.

It will

1. Determine if such incidents are notified to the designated person locally within the HSE as well as the relevant statutory agencies* as per the HSE Incident Management Policy and Procedure.
2. Determine if such incidents are investigated using the systems analysis approach as recommended by the HSE to include:
   a) Where recommendations are made determine if an action plan is developed and monitored by local management.
   b) To determine if recommendations that are applicable nationally are communicated by the local manager to the appropriate National Director for national implementation.
   c) To determine if learning points/outcomes from incident investigations are identified and communicated to relevant staff, family, carers etc. *[Reference - page 32 of the HSE Toolkit of Documentation to Support the HSE Incident Management (March 2009)]*

The appropriateness or otherwise of investigation findings and recommendations is beyond the scope of the

[1] The Mental Health Commission reviews information provided by the service in relation to the circumstances surrounding a death. If there is anything that would suggest suicide, likely suicide, missing patients, violence or any circumstance where negligence or malpractice may have been a factor, the death is classified as a sudden unexplained death by the Commission. However, for the purpose of this audit only deaths where the information provided suggests suicide or likely suicide are included.

[2] A "centre" means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act.

audit. The findings from this audit are not intended to validate or invalidate investigation findings.

*For the purposes of this audit there is a prior assumption that all deaths in approved centres are reported to the MHC. This information is validated and published by the MHC.

The audit set-out to include 19 incidents from 17 approved centres. Sixteen of the incidents occurred in 2011 and three of the incidents occurred in 2010. A total of 12 incidents from 11 approved centres were included in the final analyses. Two approved centres did not return any data; the data returned from one approved centre was incomplete and based on the information returned four incidents were deemed to outside the immediate scope of the audit. Of the 12 incidents audited investigation reports were received in respect of eight incidents.

3. SIGNIFICANT FINDINGS

1. Ninety-two per cent (n = 11/12) of incidents of sudden, unexplained death audited were notified to designated persons in accordance with legislation and HSE policy and procedures albeit the audit team had to rely on circumstantial evidence to determine compliance in some cases. Conclusive validation was not possible in these cases due to a lack of supporting documentation.
2. The audit team found limited evidence that the incidents of sudden, unexplained death audited were investigated using the systems analysis methodology. Only one of eight investigations audited was fully consistent with the systems analysis methodology. Three were found to be partially consistent with some elements of the methodology applied. There was little or no evidence that the systems analysis approach was applied in the other four cases.
3. In general, care/service delivery problems were not highlighted in accordance with the guidance. While there was some attempt by some investigation teams to identify contributory factors they were not linked to care/service delivery problems. Similarly, where recommendations were made they were not linked to contributory factors. Recommendations were made in six of the eight reports audited.
4. Action plans to address recommendations were developed in three of the six cases where recommendations were made. Where action plans were not developed, the audit team did see evidence to suggest that measures were being taken to address the majority of recommendations made in the other three reports.
5. Overall, the quality of reports varied considerably with little evidence of a standardised approach to how investigations are conducted.

4. RECOMMENDATIONS

1. Approved centres should ensure that the HSE's Office of Mental Health Services is formally notified of incidents of sudden, unexplained death. This should include incidents of sudden, unexplained death that occur in the approved centre along with incidents that occur while patients are on leave (but not discharged) from the approved centre.
2. Approved centres should ensure that a record of all persons notified of an incident of sudden, unexplained death is kept e.g., entry in patient notes, copies of e-mails, notes of telephone calls etc. and that this information is easily retrievable.
3. The NIMT should review the training being provided on the systems analysis methodology. Consideration should be given to putting in place some post training assessment with a view to ensuring that participants are in a position to properly apply the systems analysis methodology when conducting investigations.
4. Commissioners of investigations/senior management should ensure that the chair of investigation teams (at a minimum) is sufficiently trained and experienced in the systems analysis methodology.
5. Consideration should be given to identifying a number of people in each HSE Area who are trained and competent in the systems analysis methodology and who can be called upon to facilitate an investigation.
6. The NIMT should include suggested timeframes for each stage of the investigation process in its guidance document 'Guideline for Systems Analysis Investigation of Incidents and Complaints –

November 2013).

7. Commissioners of investigations/senior management should ensure that timeframes are agreed at the start of the investigation process, that they are adhered to and that they are monitored throughout the process.

5. CONCLUSION

The information submitted provides the basis for reasonable assurance that incidents of sudden, unexplained death are notified in accordance with the legislation and HSE policies and procedures albeit the audit team had to rely on circumstantial evidence to determine compliance in some cases. However, the audit team is unable to provide assurance that incidents of sudden, unexplained death are investigated using the recommended systems analysis methodology. The quality of investigations audited varied considerably and there was little evidence of a standardised approach to investigations. Although deficits have been identified, the audit team recognises the work of those investigation teams who acknowledged areas for improvement and made recommendations that may mitigate the likelihood of a similar incident occurring.

6. ACKNOWLEDGEMENT

The audit team wishes to acknowledge the cooperation and goodwill afforded them by all persons who participated in this audit and in particular the nominated liaison persons.