Oifig an Stiúrthóra Náisiúnta Cúnta
Oibríochtaí Meabhairshláinte

Ospidéal Naomh Lómáin, Baile Phámar,
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Deputy Mark Ward.
Dail Eireann,
Leinster House,
Kildare Street,
Dublin 2.

17th April 2024

Reference: **PQ Number 12144/24 and REPDR/24/02301**
PQ Question: To ask the Minister for Health the number of deaths in approved centres and mental health services reported to the coroner for the past ten years; the follow up procedures when a death is reported in an approved centre; if records of findings are maintained; and if he will make a statement on the matter. -Mark Ward

Rep Details: REPDR/24/02301 PQ 12143/24 - LATE REFERRAL PQ FROM DOH (SHOULD HAVE BEEN REFERRED WITH PQ 12144/24) To ask the Minister for Health the number of reviews of reported deaths carried out by the Standards and Quality Assurance division of the Mental Health Commission in each year of the past ten years; and if he will make a statement on the matter -Mark Ward

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Dear Deputy Ward,

The Health Service Executive has been requested to reply directly to you in the context of the above mentioned matters, which you submitted to the Minister for Health for response. I have examined the correspondence and the following outlines the current position.

The HSE does not hold records on the number of death in approved centres/mental health centres reported to the coroner.

Any death within a mental health service is considered a category 1 incident which is rated as Extreme or Major as per the HSE's Risk Impact Table and is notified and managed in line with the HSE Incident Management Framework 2020 which includes reporting requirements external to the service. All mental health services are required to report to the Mental Health Commission of quality and safety notifications relating to deaths.

As per the HSE Incident Management Framework 2020
The Serious Incident Management Team (SIMT) is an important role of the governance arrangements for the management of Category 1 incidents. The SIMT has two key responsibilities:

1. *To meet on a scheduled basis to monitor and gain assurance in relation to the on-going management of all Category 1 incidents within the service and;*

2. *To convene on an unscheduled basis and within 5 working days of a Category 1 incident being notified to the SAO in order to gain assurance in relation to any immediate actions required and to conduct a preliminary assessment to inform the requirement for further reviews".*

Should the Senior Accountable Officer accept from the SIMT that a further review is required they will then commence to commission a review by developing Terms of Reference and appointing a Review Team. All reviews are required to be carried out in keeping with the principles of fair procedures and natural justice.

Once a review is complete from a patient safety and service improvement perspective services consideration is given to completion and circulation of a learning summary which sets out a brief description of the background to the incident and the learning adduced.

The link to the HSE Incident Management Framework is here:

HSE - Incident Management Framework and Guidance 2020

Mental Health Commission: Quality and Safety Notifications

The Mental Health Commission (MHC) aims to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the Mental Health Act 2001-2018. Approved centres and other community mental health services are required to submit Quality and Safety Notifications to the Commission, pursuant to the Act. These requirements apply to HSE Services and independent/private mental health services.

There are numerous Quality and Safety Notifications which relate to incidents, adverse events and regulated practices in approved centres'. These include:

- Child Admissions
- Deaths
- Incident Reporting
- Serious Reportable Events
- Overcapacity
- Operational Bed Capacity
- Electro-Convulsive Therapy
- Restrictive Practices

All notifications received by the Commission are reviewed by the Standards and Quality Assurance (S&QA) division of the MHC, to ensure the quality and safety of care provided to the residents of approved centres and service users in receipt of mental health services. All Quality and Safety Notifications are required to be submitted to the MHC via the Comprehensive Information System (CIS).

For further Information and guidance on reporting requirements can be found by consulting with the Guidance Document on Quality and Safety notifications issued by the Mental Health Commission which can be found here: QSNGuidanceNotificationsJan2023.pdf (mhcirl.ie)

In terms of reporting a death to the coroner sudden, unexplained or violent deaths should be reported to the coroner by:

- A healthcare professional, if the death was due to natural causes in a nursing home or if the doctor had not seen the deceased within one month before their death
- The Garda Síochána, if the death was from unnatural causes
- The deceased person's doctor

- A funeral undertaker
- The Registrar of deaths
- Any householder and any person in charge of an institution or premises where the person who died was living

The Garda Síochána will assist the coroner by:

- Arranging formal identification of the body of the deceased by someone who knew them
- Providing a report on the circumstances of the death to the coroner
- Taking statements relating to the death, if necessary

There are many types of deaths which must be reported to the coroner. Further information can be found here:

https://www.gov.ie/en/service/e6ab3-report-a-death-to-the-coroner/
https://www.citizensinformation.ie/en/death/sudden-or-unexplained-death/coroners/#403e65

In relation to the number of reviews of reported deaths carried out by the Standards and Quality Assurance Division of the Mental Health Commission, this is a matter for the MHC to respond to.

I trust this information is of assistance to you.

Yours Sincerely,

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Ms Dervila Eyres
Assistant National Director, Head of Operations
HSE Mental Health Services