HSE Internal Audit Division,
St. Columba's Hospital,
Thomastown,
Co. Kilkenny.
Tel: 087 9568746

INTERNAL AUDIT REPORT

REVIEW OF THE OPERATION OF HSE STANDARDS AND RECOMMENDED PRACTICES FOR POST MORTEM EXAMINATION SERVICES

REF: MT001ASOP0222

DATE: 18 February 2022

To:	Liam Woods, National Director, Acute Operations, HSE Colm Henry, Chief Clinical Officer, HSE Anne O'Connor, Chief Operations Officer, HSE
From:	David Langton, General Manager, Internal Audit, HSE
Report Prepared By:	David Langton, General Manager, Internal Audit, HSE & John Tuohy, Internal Audit Manager, HSE
Report Reviewed By:	Alan Moran, Assistant National Director, Internal Audit, HSE
Report Approved By:	Geraldine Smith, National Director, Internal Audit, HSE
Distribution:	Margaret Brennan, Assistant National Director, Quality and Patient Safety Lead, Acute Operations, HSE Angela Fitzgerald, Assistant National Director, Acute Operations, HSE Killian McGrane, Director of National Women's & Infants Health Program, HSE Geraldine Smith, National Director, Internal Audit Alan Moran, Assistant National Director, Internal Audit, HSE Mike Corbett, Internal Audit Liaison, Acute Operations, HSE Stephen Mulvany, Chief Financial Officer, HSE Mairead Dolan, Assistant Chief Financial Officer, HSE

Executive Summary

Review of the Operation of HSE Standards and Recommended Practices for Post Mortem Examination Services

I. Audit Objective

The audit objective was to determine the assurance level that can be given to management that the requirements of the *"Health Service Executive Standards and Recommended Practices for Post Mortem Examination Services"* (2012) are being complied with.

II. Audit Assurance Level

The audit findings indicate that the level of assurance that may be provided to management about the adequacy and effectiveness of the governance, risk management and internal control system in the area reviewed is **UNSATISFACTORY**.

III. Key Audit Findings

The audit findings are detailed in the main body of this report and key findings are summarised below:

- Various issues were noted with the *"Health Service Executive Standards and Recommended Practices for Post Mortem Examination Services",* i.e. "The Policy". It has not been reviewed since implementation in 2012, leading to impracticalities with the administrative processes specified for mortuary staff. Also, it does not specify guidelines/timelines to be followed where issues arise with the ultimate disposal of a retained organ. This has led to longer retention periods than desired at numerous hospital sites. **(Findings 1.1 - 1.6)**
- Inappropriate organ disposal methods were noted at University Hospital Limerick and Our Lady of Lourdes Hospital Drogheda. **(Finding 2.1)**
- Issues around the retention of organs related to perinatal post mortems were identified at a number of hospital sites. Significant delays were noted in relation to the sensitive disposal of organs related to post mortems performed by Consultant A, a retired Perinatal Pathologist working on an ad hoc basis for the HSE. The HSE is overly reliant of the services of Consultant A, and another retired Perinatal Pathologist. **(Findings 3.1 & 3.2)**
- The relationship between the HSE and the Coroner Service is not defined or documented. There are disparities and inconsistencies in practices, communication and responsibilities between different districts. For example a number of coroners only give verbal authorisation for post mortems while others give written consent. **(Finding 4.1)**

IV. Table of Recommendations

The number of audit recommendations by ranking level is summarised below. Details of the recommendations are given in Section VI of the main report.

	Recommendations	Of which Potentially Systemic
HIGH	6	6
MEDIUM	2	-
LOW	-	-
Total	**8**	**6**

Main Report

Review of the Operation of HSE Standards and Recommended Practices for Post Mortem Examination Services

I. Background

Post mortem examination is an important part of clinical care. It is one of the most informative investigations in medicine and can provide objective information on the cause of death, which is of value to the family of the deceased, healthcare professionals and other interested parties. From the perspective of the bereaved families, post mortem examination can also provide information about the risk of inherited diseases, which might be of benefit to family members in seeking necessary care and treatment. In addition, family members may be comforted by the knowledge that information gained at post mortem examination can improve understanding of how disease is caused, thus advancing medical knowledge and helping others by contributing to the fight against disease and how it can best be treated.

Post mortem examination practices in Ireland came under public scrutiny in late 1999 and 2000 following inquiries held in England, which highlighted concerns about post mortem examination practices there. Questions were raised about the quality of information communicated to relatives of deceased persons regarding the post mortem examination and the practice of organ retention in Ireland.

This scrutiny of post mortem examination practices resulted in the establishment of the Dunne Inquiry by the then Minister of Health and Children. This Inquiry ran from April 2000 until March 2005. The report which resulted from the Dunne Inquiry was not published, and in May 2005 the Government approved the appointment of Dr. Deirdre Madden, to complete a final report on post mortem practice and organ retention.

Between 2006 and 2009, three reports were issued related to Post Mortem Practices in Ireland:

- **The Report of Dr. Deirdre Madden on Post Mortem Practice and Procedure (2006)** - This report aimed to set out the general facts in relation to paediatric post-mortem practice in Ireland from 1970 to 2000, the way in which information was communicated to parents of deceased children in relation to post-mortem examinations, and how these practices might be improved upon for the future.
- **Report of the Working Group on Post Mortem Practice (2006)** – This report looked at establishing best practice for Post Mortem Services in Ireland.
- **The Willis Report (2009)** –Dr. Madden, in her 2006 report, recommended that; "*An independent audit must be carried out of currently retained organs in all hospitals in the State".* To action this recommendation the HSE commissioned Michaela Willis MBE, the then Chief Executive of the National Bereavement Partnership in the UK to lead the independent audit. The report looked at currently retained organs in all hospitals in the State. Its purpose was to assist the HSE to determine priority areas for action and inform the development of standards by identifying areas of good practice and highlighting areas for improvement. An associated report was issued about specific issues identified at the Rotunda Hospital in relation to the retention of organs following perinatal post mortems, i.e. **The Carter Report (2009)**

The HSE established a National Advisory Group to review previous guidance in light of the recommendations made in these reports and to oversee the development of standards and recommended practices for post mortem examination. This led to the publication of the *"Health Service Executive Standards and Recommended Practices for Post Mortem Examination Services"* (2012), i.e. ("The Policy") the aim of which is to drive high quality post mortem examination services through the reflection of learning from key reports on post mortem practice and procedures, through defining and embedding of good practice in key areas relevant to post mortem examinations (coroner and hospital) and supporting an effective interface between the Health Service Executive and the Coroner Service in relation to coroner's post mortem examinations.

The recommended practices can be summarised by 5 key points as follows:

1. Communication with families regarding the hospital post mortem examination
2. Communication with families regarding the coroner's post mortem examination
3. Consent and the post mortem examination
4. Records management following coroner and hospital post mortem examination
5. Storage, management, transportation and ultimate disposition of tissue samples and retained organs following post mortem examination

The Policy deals with 2 separate types of Post Mortem; Coroner and Hospital.

Coroners are obliged by law (Coroners Acts 1962) to inquire into and investigate certain deaths as set out by the Act and subsequent amendments. Consent from the family of the deceased **is not required** if a post mortem examination is ordered by the coroner. The coroner's post mortem examination includes the removal and retention of organs, tissues and/or other body fluids for detailed laboratory examination and diagnosis for the purpose of establishing the cause of death and any other relevant matters in relation to the death. Consent is required from the family of the deceased for the continued retention of organs for any purpose once the coroner's post mortem examination and any other legal functions are complete.

A hospital post mortem examination is carried out at the request of the family of the deceased, or at the request of the deceased's treating clinician to gain a fuller understanding of the deceased's illness or condition, the possible effects of treatment provided to the deceased prior to death, possible implications for family members and to enhance the provision of medical care for future service users. Consent **is required** from the family of the deceased for a hospital post mortem examination including the removal and retention of organs, tissues and/or other body fluids in all situations in line with HSE guidance and current Standards of best practice.

In practice, over 98% of all post mortems performed across the HSE Hospital System are coroner post mortems. Presented in **Appendix 1** is the number of post mortems performed in 2021 by site, and the percentage split of coroner and hospital post mortems. The total number of post mortems performed in 2021 across HSE hospitals was 5,073, with the number performed relatively stable year on year.

In late April 2020, the management teams of Cork University Hospital ("CUH") and Cork University Maternity Hospital ("CUMH") were informed that perinatal organs, which had been stored following post mortem examination, had been sent for incineration on two occasions (25th March 2020 and 2nd April 2020). This was not in keeping with the established systems and processes for the management of perinatal organs. The Policy recommends all organs retained from a post mortem be disposed of in a sensitive manner. In general 3 options are available to families;

1. Hospital arranged cremation of the organs; with or without family involvement, dependent on the preference documented.
2. Hospital arranged burial of the organs; with or without family involvement, dependent on the preference documented.
3. The organs are returned to family members for ultimate sensitive disposal by themselves.

It was established that 18 couples, bereaved parents, had given prior permission for the hospital to make arrangements for the disposal of the retained organs, and had a clear expectation that these arrangements would be for burial or cremation. As at the date of issuance of the first draft of this report two separate reviews were ongoing into these incidents.

The HSE Acute Operations Division contacted the Internal Audit Division the week of 4th October 2021 to request a review be performed on the operation of the Standards across all public hospitals. The CEO of the HSE also

communicated with the board on 29th October 2021 indicating that Internal Audit would perform an independent audit of compliance in this area specifically focused on:

- The information provided to families.
- Securing relevant consent from families.
- The ultimate disposal of retained organs.

All 25 HSE hospitals where post mortems are carried out are presented in **Appendix 2**. This review focused on the post mortem practices of all these hospitals' mortuaries.

II. Audit Objective

The audit objective was to determine the assurance level that can be given to management that the requirements of the *"Health Service Executive Standards and Recommended Practices for Post Mortem Examination Services"* are being complied with.

Management are responsible for the system of governance, risk management and internal controls. The audit work was designed to provide reasonable but not absolute assurance to management about the adequacy and effectiveness of the system as applicable to the audit subject area, and does not necessarily identify all weaknesses which may exist. This report is intended solely for the use of the HSE and should not be relied on by anyone else.

III. Audit Scope and Methodology

The scope of the audit was all post mortems completed between 1 January 2018 and 31 October 2021 across all the HSE mortuaries.

The audit methodology included the following:

- The "*Health Service Executive Standards and Recommended Practices for Post Mortem Examination Services"* was reviewed to establish reasonableness of content, timeliness of review, and practicality.
- The governance structure for compliance with post mortem guidance at each of the hospitals under review was determined.
- Detailed testing of the record maintenance procedures at each of the hospitals under review was performed, in particular:
    - Information provided to families.
    - Consent provided by families.
    - Storage of bodies and organs.
    - Retention of bodies and organs.
    - Sensitive disposal of bodies and organs.
- Training records, procedural documents, and periodic reviews (where applicable) were reviewed at each of the hospitals.

A random sample of the lower of 10 post mortem files, or 10% of the total post mortem population in each mortuary was tested in detail.

Many larger hospitals perform post mortem services on behalf of other small hospitals across the HSE network. Where this practice was present Internal Audit ensured the sample included post mortems performed on behalf of all relevant hospitals. This ensured a thorough coverage of post mortem practices at, and for all HSE hospitals.

IV. Ranking of Audit Recommendations - Definitions

The audit recommendations to address findings on control weaknesses and the related risk implications are ranked High, Medium or Low, as described below.

HIGH	The recommendation addresses a significant risk of substantial financial loss, and/or of accounting error, and/or of major non-compliance with procedures, policies or regulations, and requires immediate action.
MEDIUM	The recommendation addresses a moderate risk of financial loss, and/or of accounting error, and/or of non-compliance with procedures, policies or regulations.
LOW	The recommendation addresses a minor risk of financial loss, and/or of accounting error, and/or of non-compliance with procedures, policies or regulations, but where controls or compliance can be improved.

Potentially systemic audit recommendations arise where audit findings identify risks or control weaknesses which may, in the opinion of the auditors, be replicated regionally or nationally, and which are sufficiently significant to be brought to the attention of regional or national management.

Where recommendations may have systemic implications, the rankings are shown as High (S), Medium (S) or Low (S).

V. Audit Assurance Levels - Definitions

The auditor expresses an overall opinion, based on the audit findings, on the level of assurance that may be provided to management about the adequacy and effectiveness of the system of governance, risk management and internal controls in place for the subject areas within the scope of the audit. The assurance levels are defined as follows.

UNSATISFACTORY	There are weaknesses in the system of governance, risk management and controls which create a serious and substantial risk that the system will fail or has failed to meet its objectives. Urgent action is required to improve the adequacy and/or effectiveness of the system.
LIMITED	There are weaknesses in the system of governance, risk management and controls which create a significant risk that the system will fail to meet its objectives. Action is required to improve the adequacy and/or effectiveness of the system.
MODERATE	There are weaknesses in the system of governance, risk management and controls which create a moderate risk that the system will fail to meet its objectives. Action is required to improve the adequacy and/or effectiveness of the system.
SATISFACTORY	Overall there is an adequate and effective system of governance, risk management and controls. Some improvements may be required to enhance the adequacy and/or effectiveness of the system.

VI. Audit Findings and Recommendations

Listed hereunder are the audit findings and risk implications, together with the audit recommendations and implementation dates agreed by management.

Audit Findings	Risk Implications	Recommendations	Management Comment
1. HSE Standards and Recommended Practices for Post Mortem Examination Services 2012 ("The Policy")	**1. Risk Implication(s)**		
1.1 The Policy was published in March 2012, and was due to be reviewed in 2015. This review did not take place.	1.1 The Policy may no longer represent best practice guidance for post mortem processes.	**Recommendation 1:** (Ref 1.1-1.6) The Policy should be reviewed and updated. It may be beneficial for Anatomical Pathology Technicians ("APTs") and/or Mortuary Managers to be part of the policy review process as they are most familiar with the practical application of the policy. **HIGH (S)**	The HSE Chief Clinical Officer (CCO) has committed to progressing the review and update of the standards through the National Quality & Patient Safety Directorate. The CCO process will include representation from relevant stakeholder groups including clinical and operational representatives.
1.2 The Policy is 120 pages long, and contains much repetition. Roughly 50% of the policy (i.e. 60 pages) is allocated to the process surrounding hospital post mortems. Testing performed by Internal Audit indicates that less than 1% of all adult post mortems performed are hospital post mortems, while the rest are coroner post mortems. The split for perinatal post mortems is more even. However, the policy, in its current guise disproportionately concentrates on the process to be followed related to these cases.	1.2 The length of the Policy, and the proportion of content allotted to the hospital post mortem process takes attention away from key compliance areas of the Policy such as general communication with families around the post mortem process, the maintenance of appropriate records for each post mortem, and the management, and sensitive disposal of organs where retained.	**Responsible Officer:** Chief Clinical Officer, HSE **Implementation Date:** 31st December 2022	
1.3 This is the first review of the recommended practices since the implementation of the Policy, and it has identified a number of administrative non-compliances across all hospitals audited. The presence of these items across all hospitals indicate a systemic Policy issue. Some of the common issues noted are as follows: • Healthcare records not updated for details of the post mortems performed. • Details missing from post mortem and organ retention registers such as: date and time of death, confirmation that the coroner's authorisation is on file, and date of the final post mortem report.	1.3 As described in 1.1 above.		

Audit Findings	Risk Implications	Recommendations	Management Comment
While the above are noted non-compliances with the current policy, Internal Audit is satisfied with the record keeping at hospital level, with appropriate audit trails and information available to trace all post mortems selected for testing. We are of the opinion that the policy is overly prescriptive and onerous on mortuary staff.			
1.4 The Policy does not specify the process for the ultimate disposal of organs where a next of kin chooses not to engage with the hospital, or where other issues with sensitive disposal arises. Ambiguity exists as to who makes the ultimate decision regarding the sensitive disposal of the organs. This has resulted in organs being retained across numerous hospitals for periods greater than the 1 year specified in the Policy. See below for further details (all records are at the date of the site visit): • Children's Hospital Ireland at Crumlin – organs retained for over 1 year from 24 separate post mortems (oldest relates to 2000). • St. Columcille's Hospital – 10 organs retained for over 1 year (oldest relates to 2017). • St. Vincent's University Hospital - 10 organs retained for over 1 year (oldest relates to 2017). • Midlands Regional Hospital Tullamore - 8 organs retained for over 1 year (oldest relates to 2010). • Smaller numbers of organs retained for over 1 year were noted at University Hospital Limerick (2017), University Hospital Waterford (2018), and Midlands Regional Hospital Portlaoise (2019).	**1.4** The non-prescription of guidelines and timelines to be followed where difficulties with ultimate disposal arise leads to organs being retained for long periods of time.		

Audit Findings	Risk Implications	Recommendations	Management Comment
1.5 The Policy specifies that hospitals must have a consent policy in place that covers all aspects of the post mortem process. A policy was not in place for 8 (32%) of the sites visited. 2 of these hospitals follow the HSE National Consent Policy, but this does not specifically deal with the post mortem process. **1.6** The Policy specifies that hospitals must have a transport policy governing the process. 5 (20%) of the hospitals visited were either in the process of developing a policy, or had just very recently introduced a policy in this area. The other 20 hospitals (80%) have some element of a transport policy in place governing the transfer of bodies, organs, and/or tissue samples.	**1.5** Hospital staff may not be fully informed of their responsibilities in relation to consent in the post mortem process. **1.6** Hospital staff may not be fully aware of their responsibilities in relation to the appropriate transfer of bodies, and organs.		
2. Organ Disposal Methods **2.1** Specific organ disposal issues were noted as follows: • Our Lady of Lourdes Hospital Drogheda – it was hospital policy to incinerate retained organs until 2020. Records reviewed identified 3 adult, and 1 perinatal organ disposed of by this method during the period under review, i.e. 2018-2021. • University Hospital Limerick – it was also hospital policy here to incinerate organs retained. Mortuary records reviewed identified 2 post mortems that had organs disposed of by this method since 2019. • Records are unavailable to verify the disposal method associated with 1 organ at Connolly Hospital Blanchardstown in 2019.	**2. Risk Implication(s)** **2.1** Organs were not disposed of as required by the Policy.	**Recommendation 2:** (Ref 2.1) The National Director of Acute Operations should liaise with management at Our Lady of Lourdes Hospital Drogheda, University of Hospital Limerick, and Connolly Hospital Blanchardstown to determine whether open disclosures are required related to the specific incidents identified in the findings. Reviews should also be completed to determine the number of other such instances that occurred outside the scope of this review, but since the introduction of the policy. The need for Open Disclosures, and associated remediation actions should also be considered here. **HIGH (S)**	The ND Acute Operations notes the findings of the Internal Audit Report, and will determine the need for further reviews by Internal Audit in due course. The ND Acute Operations will seek written confirmation from the HG that open disclosure occurred where non-compliances were identified.

Audit Findings	Risk Implications	Recommendations	Management Comment
		Responsible Officer: National Director, Acute Operations, HSE **Implementation Date:** 30th April 2022 **Recommendation 3:** (Ref 2.1) Internal Audit have communicated the need for a change in sensitive disposal policy to occur at both Our Lady of Lourdes Hospital Drogheda, and University of Hospital Limerick as part of our preliminary findings communication with hospital management. Both hospitals have confirmed such a change has taken place. Nonetheless, the Acute Operations Division should satisfy themselves that operations are now appropriate at both sites. **MEDIUM** **Responsible Officer:** National Director, Acute Operations, HSE **Implementation Date:** Immediate	The ND Acute Operations will liaise with the CEOs of HGs to provide assurance that sensitive disposal arrangements comply with the current standards with immediate effect.
3. Perinatal Post Mortems **3.1** Issues were identified in relation to the retention of organs from perinatal post mortems (all records are per the date of the audit site visit): • Galway University Hospital – between 2018 and 2021 perinatal organs were retained in 28 cases for periods greater than 1 year. The date range was just over 12 months to 32 months. All of the organs retained	**3. Risk Implication(s)** **3.1** Perinatal organs have been retained for far in excess of the 1 year maximum retention period specified in the policy.	**Recommendation 4:** (Ref 3.1) The National Director of Acute Operations should ensure that the necessary actions are taken to finalise any outstanding post mortem reports, thereby enabling the ultimate disposal of the retained organs in a sensitive manner, in line with families' wishes.	The ND Acute Operations will liaise with the HG CEOs to request that all necessary actions be taken to finalise any outstanding post mortem reports (where deemed concluded)

Audit Findings	Risk Implications	Recommendations	Management Comment
related to post mortems performed by Consultant A. The majority of these organs have now been disposed of, with only 4 remaining as at the date of audit. • Portiuncula University Hospital – organs related to 2 separate post mortems during the period under review were retained for 18 and 26 months respectively as the hospital waited for approval to release from the pathologist in question (Consultant A). These organs have now been released, and disposed of in line with the families' wishes. • St. Columcille's Hospital – 16 organs from 6 perinatal post mortems were held at the hospital when visited by Internal Audit. The retention period for these organs was between 18 and 32 months. All post mortems were performed by Consultant A. • Midlands Regional Hospital Tullamore – organs were retained relating to 6 separate perinatal post mortems on the date of audit visit. Organs for 5 of these post mortems were approved for release by the relevant pathologist (Consultant A) the day before the visit. These organs had been held for between 19 and 55 months. • University Hospital Limerick - organs were retained relating to 5 separate perinatal post mortems on the date of the site visit. These organs were retained for between 24 and 42 months. All post mortems were performed by Consultant A.		**HIGH (S)** **Responsible Officer:** National Director, Acute Operations, HSE **Implementation Date:** Immediate **Recommendation 5:** (Ref 3.1 and 3.2) The services provided by Consultant A should be reviewed. A determination as to whether the current services are fit for purpose should be performed, and associated remediation actions taken (if required). **HIGH (S)** **Responsible Officer:** National Director, Acute Operations, HSE **Implementation Date:** 30th June 20222	with the relevant parties, noting that the availability of perinatal pathologists to complete this work may be contingent on current availability as per Recommendation 5 and 6. The ND Acute Operations will request the CEOs of Hospital Groups who are using the services of consultant A and other external resources to review their current arrangements to determine if the service is fit for purpose. The Hospital groups will need to determine alternative arrangements, if consultant A's service is not deemed appropriate. These new arrangements would be pending the completion of Recommendation 6.
3.2 Internal Audit observed a general lack of Perinatal Pathology consultant resources during the site visits conducted,	**3.2** There may be an inability to provide perinatal pathology services as required	**Recommendation 6:** (Ref 3.2) A review into the ongoing provision of perinatal	A review of perinatal pathology services will be accelerated through the

Audit Findings	Risk Implications	Recommendations	Management Comment
necessitating the employment of retired consultants. Consultant A is 70+ years of age, retired, and works on an ad hoc basis for the HSE. A similar arrangement also exists with another retired perinatal pathologist.	once Consultant A and B decide to no longer provide their services to the HSE.	pathology services nationwide should be performed by the Acute Operations Division. An action plan should be devised and implemented to address the likely shortages of perinatal pathologists going forward. **HIGH (S)** **Responsible Officer:** Director of NWIHP, HSE **Implementation Date:** 31st December 2022	current work force planning exercise undertaken by the National Women's & Infants Health Program. Once completed, agreed action plans will be developed and implemented to address the resource issues identified. While there have been investments in this area over the last number of years, the appointment of additional perinatal pathologists is contingent on both approval and availability. Appointments of qualified candidates have occurred where a period of additional training/ secondment is made a condition of appointment resulting in an average two-year cycle before the substantive post being filled.

Audit Findings	Risk Implications	Recommendations	Management Comment
4. The Coroner System **4.1** Relationships between hospitals and coroners vary between regions. • In many hospitals written confirmation regarding the authorisation for a coroner's post mortem is not received, e.g. Galway University Hospital, Sligo University Hospital, University Hospital Waterford and Portiuncula University Hospital. In other areas a C71 form (Garda Incident form) is received, which is deemed to be the authorisation, e.g. Our Lady's Hospital Navan, and Our Lady of Lourdes Hospital Drogheda. • In Sligo and Letterkenny the coroner directly liaises with families regarding the wishes for the ultimate disposal of retained organs. These discussions, and decisions are not documented by the relevant hospitals. Recommendations 3.5 and 3.8 respectively of the Madden Report (2006) stated that; *"The legal position pertaining to the status of organs lawfully retained as part of a coroner's post-mortem examination must be clarified by legislation. Pathologists performing post-mortem examinations at the request of a coroner must have clear protocols agreed with the coroner for the retention of organs….. The cost implications of these options should also be dealt with by the legislation."* Internal Audit found there to be ambiguity around the responsibilities of coroners and Hospitals where a coroners	**4. Risk Implication(s)** **4.1** Different processes result in different information being held on file across hospitals. Should an issue with a post mortem arise, the required documentation may not be held on file to verify the hospital acted as requested/required.	**Recommendation 7:** (Ref 4.1) A review should be commissioned into the coroner relationships that exist across the HSE Hospital network to establish improved, consistent practices going forward. **HIGH (S)** **Responsible Officer:** National Director, Acute Operations, HSE **Implementation Date:** 30th September 2022	The Coroner's role is independent and governed by legislation. There is an opportunity however to review and update the current HSE templates to standardise the documentation of decisions made in respect of Coroner post mortems, and the NQPS Directorate will consider this during stakeholder engagement. Following such engagement, further standardisation of practices outside the scope of the HSE, considered beneficial, can be noted to the DOH for their consideration and liaison with the Department of Justice.

Audit Findings	Risk Implications	Recommendations	Management Comment
Post Mortem is performed. Specifically, this ambiguity exists in relation to the retention of organs, communications with families when organs are retained, and who should bear the costs of the ultimate disposal of organs from coroner Post Mortems. Legislation has not yet been passed to clarify the relationship between the HSE and the coroner, and the recommendations originally from the Madden Report have yet to be actioned appropriately.			
5. Other matters of note	**5. Risk Implication(s)**		
5.1 Coombe Women and Infants University Hospital – no organ retention register was in place as at the date of the site visit (13.12.2021).	**5.1** A list of organs retained is not kept in line with the policy, which may lead to the mismanagement of retained organs.	**Recommendation 8:** (Ref 5.1-5.5) The items raised in findings 5.1 – 5.5 were discussed with relevant hospital management as part of the preliminary findings process associated with this review. The Acute Operations Division should follow-up with management at each of the hospitals mentioned to ensure appropriate remediation measures have being put in place. **MEDIUM** **Responsible Officer:** National Director, Acute Operations, HSE **Implementation Date:** 30th April 2022	The ND Acute Operations will follow up with the respective CEOs of the HGs as mentioned to discuss the remediation measures that are in place.
5.2 Our Lady's Hospital Navan – the Mortuary is currently staffed by one Mortuary Manager, who is a qualified anatomical pathology technician (APT), with an average of 250 post mortems performed per annum. Back-up cover is provided by one of the APT's in Our Lady of Lourdes Drogheda, however hospitals are managed by two different Hospital Groups and there is no Service Level Agreement in place for this arrangement.	**5.2** Inability to perform the services as required should something unforeseen occur.		
5.3 Our Lady's Hospital Navan - currently when a body is transferred from the Hospital to the Mortuary it is through a car park. The outdoor element of the transfer is approx. 300 metres and the trolleys used are not designed for outdoor transportation.	**5.3** Inappropriate transportation of deceased individuals through a public area.		

Audit Findings	Risk Implications	Recommendations	Management Comment
5.4 Portiuncula University Hospital - Currently details of post mortems are communicated verbally. PUH Management confirmed they are in the process of creating adult post mortem information booklets (03.12.2021).	**5.4** Family members may not be informed of all elements of the process as required by the policy.		
5.5 St. Vincent's University Hospital - SVUH complete all hospital arranged cremations in batches. The process is to collate all retained organs, and cremate together. In general batch cremations occur once a year, and this aims to ensure organs are disposed of within the 1 year timeframe specified in the policy. However, during 2019 the volume of organs held was less than usual and resulted in no cremation taking place. This meant that when the 2020 cremation took place a number of the organs sensitively disposed of fell outside of the 1 year timeframe. Beaumont Hospital follow a similar process to SVUH, and this may also result in organs being held for greater than the 1 year timeframe.	**5.5** Organs may be held for greater than 12 months prior to their sensitive disposal, i.e. longer than the maximum retention period specified in the policy.		
5.6 The following observations were also noted in the testing performed by Internal Audit; • Training in relation to the 2012 policy was not readily provided across the HSE. Furthermore, many APTs have not received soft skills training which may be of benefit given their interactions with bereaved families. • An adult post mortem booklet was not available at one hospital. • Cremations were not offered at all locations due to logistical difficulties with offering such a service, i.e. no local crematorium.	**5.6** Individuals involved in the post mortem process may not be aware of their responsibilities. APTs may not have received training as required. Families may not be thoroughly informed of all elements of the post mortem process. Families may not be given options regarding the sensitive disposal of organs. An audit trail may not be available to verify that the coroner was informed of a reportable death as required. Religious beliefs of those deceased may not be catered for.		

Audit Findings	Risk Implications	Recommendations	Management Comment
• A notification of reportable deaths to the coroner as prescribed on page 116 of the Policy is not readily completed at many hospitals. • 1 hospital uses a plot in a Catholic cemetery rather than a multi-denominational cemetery to bury organs. • Mortuary, post mortem and organ retention registers are generally held in paper format. There are no standard national templates and each hospital has created their own local registers.			

VII. Summary of Recommendations with Implementation Plan

Rec. No.	Audit Finding	Recommendation	Ranking	Responsible Person	Implementation Date
1	1.1 - 1.6	The Policy should be reviewed and updated. It may be beneficial for Anatomical Pathology Technicians ("APTs") and/or Mortuary Managers to be part of the policy review process as they are most familiar with the practical application of the policy.	HIGH (S)	Chief Clinical Officer, HSE	31st December 2022
2	2.1	The National Director of Acute Operations should liaise with management at Our Lady of Lourdes Hospital Drogheda, University of Hospital Limerick, and Connolly Hospital Blanchardstown to determine whether open disclosures are required related to the specific incidents identified in the findings. Reviews should also be completed to determine the number of other such instances that occurred outside the scope of this review, but since the introduction of the policy. The need for Open Disclosures, and associated remediation actions should also be considered here.	HIGH (S)	National Director, Acute Operations, HSE	30th April 2022
3	2.1	Internal Audit have communicated the need for a change in sensitive disposal policy to occur at both Our Lady of Lourdes Hospital Drogheda, and University of Hospital Limerick as part of our preliminary findings communication with hospital management. Both hospitals have confirmed such a change has taken place. Nonetheless, the Acute Operations Division should satisfy themselves that operations are now appropriate at both sites.	MEDIUM	National Director, Acute Operations, HSE	Immediate
4	3.1	The National Director of Acute Operations should ensure that the necessary actions are taken to finalise any outstanding post mortem reports, thereby enabling the ultimate disposal of the retained organs in a sensitive manner, in line with families' wishes.	HIGH (S)	National Director, Acute Operations, HSE	Immediate
5	3.1 & 3.2	The services provided by Consultant A should be reviewed. A determination as to whether the current services are fit for purpose should be performed, and associated remediation actions taken (if required).	HIGH (S)	National Director, Acute Operations, HSE	30th June 2022

Rec. No.	Audit Finding	Recommendation	Ranking	Responsible Person	Implementation Date
6	3.2	A review into the ongoing provision of perinatal pathology services nationwide should be performed by the Acute Operations Division. An action plan should be devised and implemented to address the likely shortages of perinatal pathologists going forward.	HIGH (S)	Director of NWIHP, HSE	31st December 2022
7	4.1	A review should be commissioned into the coroner relationships that exist across the HSE Hospital network to establish improved, consistent practices going forward.	HIGH (S)	National Director, Acute Operations, HSE	30th September 2022
8	5.1 – 5.5	The items raised in findings 5.1 – 5.5 were discussed with relevant hospital management as part of the preliminary findings process associated with this review. The Acute Operations Division should follow-up with management at each of the hospitals mentioned to ensure appropriate remediation measures have being put in place.	MEDIUM	National Director, Acute Operations, HSE	30th April 2022

VIII. Appendix 1 – Number of Post Mortems performed in 2021, and estimated coroner and hospital post mortem split

Hospital Name	Hospital Group	No. of PMs performed in 2021	% Coroner PM	% Hospital PM
Mater Misericordiae University Hospital (ceased performing PMs since March 2020)	**Ireland East Hospital Group**	-	-	-
National Maternity Hospital Holles St		27	41%	59%
Our Lady's Hospital Navan		225	100%	-
St. Columcille's Hospital		242	100%	-
St. Vincent's University Hospital		102	100%	-
Coombe Women and Infants University Hospital	**Dublin Midlands Hospital Group**	45	34%	66%
Midland Regional Hospital Portlaoise		79	100%	-
Midland Regional Hospital Tullamore		237	100%	-
Naas General Hospital		201	100%	-
St. James's Hospital (ceased performing PMs since March 2020)		-	-	-
Tallaght University Hospital		99	100%	-
University Hospital Limerick	**University of Limerick Hospital Group**	399	100%	-
University Hospital Kerry	**South/South West Hospital Group**	238	100%	-
University Hospital Waterford		560	100%	-
Cork University Hospital		1,050	96%	4%
Beaumont Hospital	**RCSI Hospital Group**	123	98%	2%
Connolly Hospital Blanchardstown		207	99%	1%
Our Lady of Lourdes Hospital Drogheda		197	100%	-
CHI at Crumlin	**Children's Hospital Group**	46	93%	7%
CHI at Temple Street		24	100%	-
Galway University Hospital	**Saolta University Health Care Group**	428	95%	5%
Letterkenny University Hospital		158	99%	1%
Mayo University Hospital		160	100%	-
Portiuncula University Hospital		80	100%	-
Sligo University Hospital		146	95%	5%
Total		**5,073**	**98%**	**2%**

IX. Appendix 2 – Hospitals where Post Mortems were performed during the scope of the review (i.e. 2018-2021)

Ireland East Hospital Group	**Saolta University Health Care Group**
Mater Misericordiae University Hospital (ceased performing PMs since March 2020)	Galway University Hospital
National Maternity Hospital Holles St	Letterkenny University Hospital
Our Lady's Hospital Navan	Mayo University Hospital
St. Columcille's Hospital	Portiuncula University Hospital
St. Vincent's University Hospital	Sligo University Hospital
Dublin Midlands Hospital Group	**Children's Hospital Group**
Coombe Women and Infants University Hospital	CHI at Crumlin
Midland Regional Hospital Portlaoise	CHI at Temple Street
Midland Regional Hospital Tullamore	**RCSI Hospital Group**
Naas General Hospital	Beaumont Hospital
St. James's Hospital (ceased performing PMs since March 2020)	Connolly Hospital Blanchardstown
Tallaght University Hospital	Our Lady of Lourdes Hospital Drogheda
South/South West Hospital Group	**University of Limerick Hospital Group**
University Hospital Kerry	University Hospital Limerick
University Hospital Waterford	
Cork University Hospital	