Retained Organs Audit

2009

Michaela Willis M.B.E

Acknowledgements

I would like to acknowledge the very open and helpful way in which staff in all the hospitals and universities approached this audit. The inspections were generally informative and much good practice was observed; some visits were not easy, and on rare occasions were quite uncomfortable for staff whose established practices were being challenged. However, it was heartening to see the way in which so many people welcomed the audit, and responded with openness and genuine helpfulness to the requests made of them; it was also good to witness genuine commitment by many staff to their work.

I would also like to acknowledge the uncompromising work of the audit team, which it has been my privilege to lead, since without their considerable efforts this audit would not have been possible. In particular I would like to thank Mrs Nuala Harmey. Her experience and insight into the Irish Health Service, together with her Medical Social Work background, hospital bereavement experience, and her cultural knowledge of Ireland, were all invaluable.

Finally, I feel I must publicly acknowledge that throughout the audit, the Anatomical Pathology Technician at The Children's University Hospital Temple Street, Pat Leahy, was consistently warmly commended to us for his invaluable knowledge of the issues and his readiness to share that knowledge to assist any professionals who contact him in relation to infant deaths.

NB: Information contained within this report is correct at the time the audit was undertaken by the audit team – dates set out in table on page 8.

Michaela Willis MBE

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Terms of Reference

1. To conduct an independent audit of currently retained organs in all hospitals in the State both pre and post 2000.
2. To assist the Health Service Executive to determine priority areas for action and inform the development of standards by:
    - Identifying areas of good practice
    - Highlighting areas for improvement

Also provide individual hospital feedback within the report to support good practice and help set priorities at a national and local level.

Executive Summary

As an external independent audit process the following points summarise the main findings of the report.

1. The total number of organs retained across the State is **21,487** and **2** 'sets' of organs.[1] This total is comprised of **2,454** specimens held in Universities/College's across the State, **16,759** are organs that were retained at Post Mortem Examinations carried out Pre-2000 and **2,274** are organs that were retained at Post Mortem Examinations carried out since 2000.

2. The pre 2000 organs currently retained are held in the following hospitals:

   - National Maternity Hospital, Holles St. (13,850)[a]
   - Rotunda Hospital (2,700)
   - Our Lady's Children's Hospital, Crumlin (155)

   The hospitals did not take action in relation to these pre 2000 organs following the ERHA meeting of the 24th March 2004.[2]

   - Coombe Women's Hospital (36, Museum specimens)
   - Cork University Hospital and Cork University Maternity Hospital (4)
   - Galway University Hospital (2)
   - St. Columcille's, Loughlinstown (9)
   - Beaumont Hospital (3)

   The majority of post 2000 organs currently retained are held in the following hospitals:

   - Rotunda Hospital (1,083)
   - National Maternity Hospital (673)[b]
   - Beaumont Hospital (138)

3. Validation visits to 36 hospitals and 5 universities were carried out. All universities were validated. All hospitals were validated with the exception of one hospital, which required a separate investigation. This hospital has been validated from February 2008.

4. Practice is much improved over pre 2000 practice and much guidance has been implemented. There are a good number of hospitals with ***excellent documentation***. However, there is still need for improvement with documentation and tracking/logging with regard to human organs removed at post-mortem examination.

5. Formal systems for review and audit of post-mortem examination and organ practice are needed. Training alone is insufficient. Practice must be systematically reviewed.

6. Consent is sought with regard to a hospital post-mortem examination by doctors in **ALL** hospitals, supported by a multidisciplinary team in some cases. ***This is excellent practice***. However, the practice of seeking consent needs to be underpinned by suitable training, of which there is limited evidence, despite considerable evidence to show it is needed.

7. Policies and Standard Operating Procedures in some hospitals are ***excellent*** and properly version controlled. However, there is a need for those hospitals that are not as conversant with such good practice to address this immediately as some fall well below acceptable standards.

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[a] Practice at the hospital was to retain sets of organs and this count relates to 1,527 post mortem examinations
[b] Practice at the hospital was to retain sets of organs and this count relates to 72 post mortem examinations

8. There is a need to facilitate the implementation of a proper training, education and Continuing Professional Education (CPE) infrastructure for those providing care for the bereaved in relation to a post-mortem examination and for those responsible for seeking consent to a post-mortem examination.

9. There is an urgent need for accredited training and Continuing Professional Education for staff working with the deceased in the mortuary.

10. Bereavement services are in general very good in children's and maternity hospitals. However, within hospitals the level of support services can be variable. In particular inter hospital transfers for post-mortem examination purposes can cause difficulties and these areas require improved focus to ensure that appropriate family support is in place. There is less service provision with regard to bereavement services for adults.

11. Consolidation, centralisation and integration of post mortem examination services, whilst maintaining support services for the bereaved in each hospital or a centralised support service with a local contact, needs further consideration.

12. Forward looking is essential for professionals; in general it was observed that many have developed/accepted/adopted a more contemporary way of working especially when communicating with families; however others would benefit from CPE to assist with the transition.

The audit team considers that the data and audit results presented in this report demonstrate that significant improvements have been achieved in these areas in recent years. The report itself provides a strong evidence base for the further development of services and should assist in promoting continuous improvement within the context of robust healthcare governance systems. **It must be noted that this report relates to the position evidenced in each hospital at the time of their audit visit (dates included in hospital validation status summary on page 8). In some cases additional information was elicited and this is noted at the end of each individual section.

Hospital Validation Status Summary

Hospital	Status*	Date last visit
AMNCH	Validated √	19/11/2007
Beaumont Hospital	Validated √	19/12/2007
Cavan General Hospital	Validated √	10/09/2007
CUH, Temple St	Validated √	28/11/2007
Connolly Hospital Blanchardstown	Validated √	25/11/2008
Coombe Women's Hospital	Validated √	01/10/2007
Cork University Hospital and Cork University Maternity Hospital	Validated √	14/12/2007
Galway University Hospitals (UHG and MPUGH)	Validated √	30/08/2007
Kerry General Hospital	Validated √	18/07/2007
Letterkenny General Hospital	Validated √	22/11/2007
Louth County Hospital	Validated √	26/09/2007
Our Lady of Lourdes Hospital, Drogheda	Validated √	25/09/2007
Mater Misericordiae Hospital	Validated √	07/11/2007
Mayo General Hospital	Validated √	07/08/2008
Mercy University Hospital, Cork	Validated √	30/07/2007
Mid Western Regional Hospital, Dooradoyle	Validated √	13/12/2007
Mid Western Regional Hospital, Nenagh	Validated √	06/08/2007
Mid Western Regional Maternity Hospital, Limerick	Validated √	0708/2007
Midland Regional Hospitals, Tullamore, Portlaoise and Mullingar	Validated √	09/08/2007
Naas General Hospital	Validated √	05/09/2007
National Maternity Hospital, Holles St.	Validated √	16/06/2009
Our Lady's Children's Hospital Crumlin	Validated √	04/12/2007
Our Lady's Hospital, Navan	Validated √	29/11/2007
Portiuncula Hospital, Ballinasloe	Validated √	30/08/2007
Rotunda Hospital	Validated √ (from Feb 2008)	01/07/2009
Sligo General Hospital	Validated √	16/09/2008
St. Columcille's Hospital, Loughlinstown	Validated √	30/11/2007
St. James' Hospital	Validated √	18/10/2007
St. Vincent's University Hospital, incorporating, St. Michael's Hospital, St. Vincent's Private Hospital	Validated √	09/10/2007
Waterford Regional Hospital	Validated √	21/12/2007

** The report describes the status of the hospital as per date of last visit. Since the last visit, some hospitals have supplied information in relation to developments and improvements they made on the foot on the visit. Information in relation to these developments and improvements was very welcome; however, it is not reflected in the description of the hospitals status as it does not pertain to the position at the time of the last visit when the audit team had the opportunity to validate material provided through inspection and interview.*

University visits took place from 30/01/2008 to 13/05/2008

Background

Two Inquiries were carried out at the beginning of this century into events at the Royal Bristol Infirmary,[3] and at the Royal Liverpool Children's Hospital – Alder Hey.[4] These Inquiries highlighted concerns in England about post-mortem examination practices and in turn led to questions being raised in Ireland, primarily relating to the retention of organs and tissue without consent, following post-mortem examination. This in turn led the Government of Ireland to establish the Dunne Inquiry, which failed to report, and subsequently the Madden Inquiry, which reported in 2005.[5]

The Madden Reports set out the general facts in relation to paediatric post-mortem examination practice in Ireland between 1970 and 2000.[5] [6] The report examined the way in which information was communicated to the parents of deceased children in relation to post-mortem examinations and the retention of organs, and highlighted the need for increased transparency in post-mortem examination consent procedures. Amongst the recommendations contained in the report Dr. Madden recommended that:

"An independent audit must be carried out of currently retained organs in all hospitals in the State."

This recommendation led the Health Service Executive to commission Michaela Willis MBE, the then Chief Executive of the National Bereavement Partnership in the UK and an Honorary Senior Lecturer at Staffordshire University, who was a Member of the Human Tissue Authority until April 2009 and a former member of the Retained Organs Commission (which oversaw a similar process in England) to lead the independent audit.

This report sets out the situation, at the time of audit visits, regarding the retention of organs at post-mortem examination in the State and presents the findings of that audit. The report also contains a number of recommendations, the implementation of which, in the view of the audit team, would strengthen the existing practice relating to post-mortem examination practice, including seeking consent, and more widely, the provision of support to bereaved people and setting priorities.

Introduction

Michaela Willis was commissioned by the Health Service Executive (HSE) to carry out the recommendation detailed in the Madden Report,[5] notably that:

"An independent audit must be carried out of currently retained organs in all hospitals in the State."

An independent audit of organs retained since 2000 was undertaken from July 2007 to September 2008 while assessing the current state of policies and practice in relation to the retention of organs and associated activities. The primary task was to validate the self-assessments carried out by hospitals of organs retained at post-mortem examination.

The Health Service Executive also required recommendations to assist in the development of national standards governing practices related to post-mortem examinations and the removal, retention, storage, use and disposal of human tissue and organs. The second section of the report provides a summary of policy and practice across all areas, with examples of good practice and areas that require priority focus, and some consideration of the present availability of bereavement services in hospitals in the Ireland. This section of the report is not hospital specific and will assist the Health Service Executive in shaping its priorities and defining the scope for its work on the development of national standards.

It is recommended that a national implementation group be convened by the Health Service Executive, to drive forward the recommendations of the Madden Report and any recommendations arising from this report. This report represents another significant step towards the implementation of those recommendations.

There are two distinct sections to this report. Section **A** is site specific and documents the findings detailing the returns provided by each individual hospital in respect of:

- Validation of currently retained organs in the State
- Consent to post-mortem examination
- Organ removal, retention, storage, use and disposal

Consideration is also given to the level of training provided to staff in a range of areas and in particular in regard to seeking consent to post-mortem examination and providing full information about post-mortem examination practice.

Section A of the report also sets out the audit method, which combined the use of a comprehensive audit tool with rigorous physical site inspections, in depth interviews and the collection of a significant portfolio of additional evidence from each hospital and also highlights areas of good practice identified throughout the audit. Also covered in Section **A** although strictly outside the original audit remit, yet considered important, are:

- Facilities within hospital for bereaved people
- Communication with bereaved people
- The provision of bereavement services

Section **B** presents a number of recommendations, action points and priorities for consideration by the Health Service Executive for implementation in the future. There are many complex and interwoven issues connected with the sensitive questions that arise from the retention of organs at post-mortem examination, not least the more general question of how we interact with bereaved people.

Aims of the Audit

To collect and analyse the data relating to currently retained organs in all hospitals in Ireland both pre and post the year 2000 by:

- Designing and disseminating a self assessment tool
- Collating and reviewing the self assessment returns
- Visiting hospitals to validate the search by:

    > Physical searches
    > Reviewing documents and policies
    > Interviewing staff
    > Seeking evidence of comprehensive organ cataloguing, tracking and disposal

- Establishing the current provision of information given to families and reviewing hospitals' and universities' consent to post-mortem examination process and documentation.
- Reviewing training and education provision in the above.
- Identifying areas of good practice, strengths and weaknesses, alongside any areas of improvement, education and training.

Hospitals' documentation and practice in relation consent to post-mortem examination, organ removal, retention, storage, use and disposal was reviewed in the context of the following:

- *'The Faculty of Pathology of the Royal College of Physicians of Ireland'* issued advice about post-mortem consent and the retention of samples in February 2000.[7] This impressive document included specific guidelines for seeking consent, recognising (well before most other authorities) parental sensitivities surrounding the retention of organs at post-mortem examination.[8]
- In 2002 the ERHA produced a model consent form for hospitals to use.[9] This sets out *'protocol/guidelines for hospitals and other relevant agencies in providing a quality response to families in relation to non-coroners post-mortem examination practice.*
- Discussions in relation to the appropriate and sensitive disposal of organs as per meeting held at the Health Board Offices, Tullamore on March 24th 2004, indicating that it was *'now appropriate to take decisions in relation to retained organs'*.[2]

Methods

The methods used to achieve the objectives of the audit were as follows:

Phase 1 – Planning and Preparation
It was essential that the proposed audit was carefully planned and constructed. It was essential that the data collection, analysis and subsequent outcomes would be thoroughly robust to ensure transparency and restore public confidence; to ensure that the relatives and friends of deceased patients, the hospitals and the people of the State were well served by the audit and would be able to rely upon the outcomes to provide a strong foundation on which to build for the future.

A detailed project plan was agreed; this included identifying the hospitals and other institutions, which were to be visited; determining who would make the visit(s) and establishing a timetable for those visits to be undertaken. Each organisation was then contacted by letter and sent a 'guidance document on validation of information systems', which outlined the process of the audit. This was to assist hospitals to establish a framework through which they could appropriately respond to the audit.

This, coupled with the appropriate audit tool, enabled a thorough baseline assessment to be conducted.
The audit tool also prompted hospitals to examine their current practices concerning post-mortem examination, consent, and the removal, storage, retention and disposal of any organs at post-mortem examination. The tool thus enabled both current practice and currently retained organ to be identified so that a better understanding of post-mortem examination practices and the current state of organ retention across the State could be obtained.[10]

Phase 2 – The Audit

Objective 1
Phase two was the audit itself, of which the self-assessment pro-forma was only a part. The concept of an organisational audit, review and evaluation was fundamental to the project and the outcomes of the audit are presented in the body of this report. The aim of the audit was to answer the strategic question posed by the Madden Inquiry, i.e:

'An independent audit must be carried out of currently retained organs in all hospitals in the State'[5]

Objective 2
At the same time the audit aimed to assess what other related services were provided within the hospitals of the State. This included focusing on areas such as mortuary facilities, bereavement support and staff training, whilst holding paramount the dignity and respect due to deceased patients and bereaved people alike.

The audit tool enabled a factual picture of each hospital/university to be established. However, the method did not rely on a paper exercise alone. It was securely founded on the dual and complementary processes of completion of a comprehensive audit tool, backed by rigorous physical inspection and staff interviews, involving one or more site visits over one or two days.

It was clear from the outset that physical searches would be necessary to validate the Nation's currently retained organs, but there would also be other benefits to visiting each site. It would allow individual staff to be interviewed, and enable the audit team to see for themselves how policies relating to consent and post-mortem examination were embedded in the organisation. This enabled the possibility of witnessing information had been provided to relatives either verbally or in writing, which further strengthened the method of the review and validated the claims of individual hospitals.

An additional benefit, in terms of meeting the objectives outlined above, was that by visiting the sites the audit team would be able to establish evidence of comprehensive organ cataloguing, tracking, storage and

disposal; hear from staff about current and on-going training in this area, whilst gleaning information about the practical implementation of policies within the hospital. It was possible to see whether policy was embedded in practice and whether processes for cataloguing, tracking, storage and recording appropriate disposal of organs were in place.

The methods for undertaking the audit allowed for far more than establishing a clear picture of National currently retained organs. This report provides an opportunity to positively support organisations and to:

- Ensure all hospitals have fully identified and declared any existing currently retained organs
- Assess current systems and processes for the provision of information to bereaved relatives around post-mortem examinations and consent
- Assess training and education needs in this area
- Identify good practice and **establish foundations for excellence in the future**.

Phase 3 - Analysis and Presentation of the Report
Phase two of the project produced an enormous amount of data, which needed to be scrutinised, validated, and analysed to allow relevant conclusions to be drawn and recommendations produced in an appropriate format. Each hospital received a copy of the page of the report pertaining to the audit visit to check for factual accuracy. Any changes requested were reviewed by the auditor and included or excluded as was appropriate. Many hospitals included updates on practices and facilities in their responses. These comments were not taken into account as they had not been evidenced and superseded the visit date (see table page 8). There were several hospitals where queries were raised, these responses are inserted as notes at the bottom of the individual hospital's section if queries had been asked of them. This report brings together all the work of the audit team in a single tangible volume for consideration by the Health Service Executive.

The report is presented in two sections:

Section A.: Site-specific validation of currently retained organs and bereavement services, including areas of good practice. This section shows clearly the validation status with regard to currently retained organs of each organisation participating in the review. This section looks carefully at the responses provided on the self-assessment, audit tool and site visits and presents the considered opinion of the audit team in some detail.

Section B : Generic section highlighting areas of good practice, including recommendations and action points.

These 3 phases concluded the work of the of the audit team, culminating in the presentation of this report. However it is essential that there is a 4th and final stage beyond the scope of this report, and that will be the implementation of the recommendations contained herein.

Phase 4 - Examination and Implementation of Findings
The final phase will be for the Health Service Executive to consider the findings presented in this report and take steps to implement the recommendations.

Implementation of the recommendations contained within this report, and the outworking of any additional work streams deemed necessary to support these recommendations, will take time. It will be for the Health Service Executive to set an appropriate time frame for the full implementation of revised working practices and the implementation of any national guidelines or advice documents. These will need to be revised following implementation of legislation and particularly the proposed Human Tissue Act once adopted into legislation.

It is crucial to have appropriate regulation and robust monitoring systems in place throughout the State to ensure that the strong foundation provided can be built upon in the future. Precisely what those mechanisms might be will be for the Department of Health to decide the consultation process on the legislative

framework is currently underway. This way forward will, over time, deliver a demonstrable change in the organisational culture with regard to post-mortem examination, consent, and the retention of organs at post-mortem examination and the care of the bereaved. Indeed considerable work in these areas is already underway and the contribution of this report is to add weight to the continuous improvement of work in these areas. Furthermore it is to be hoped that this detailed study, and the careful methodology which underpins it, will provide a catalyst for change providing an opportunity for more openness in respect of the practices of post-mortem examination, consent and organ retention, and an opportunity to give due precedence to the care of the bereaved as part of the delivery of high quality health care within the State.

Section A

Section A collates the enormous amount of data collected, which needed to be scrutinised, validated, and analysed. This section is:

A) Validation of the Nation's currently retained organs and bereavement services, including areas of good practice- site specific.

This section shows clearly the validation status with regard to current retained organs of each organisation participating in the review. This section looks carefully at the responses provided on the self- assessment, audit tool and site visits and presents the considered opinion of the audit team in some detail.

Each hospital has its own individual section, which contains 3 tables:

- TABLE A - **Currently** retained organs **pre Jan 1st 2000**
- TABLE B - **Currently** retained organs **post Jan 1st 2000**
- TABLE C - Disposal of organs **post 2000**

A total of 60 one or two day visits were made to 36 hospitals and 5 University sites between 18.7.07 and 26.9.08. There was a requirement for specific follow up correspondence and visits to some hospitals up until 1st July 2009. A comprehensive list of visits and hospitals visited is at Annex 1.

A total of 16 hospitals within Ireland submitted disclaimers, which were accepted by the audit team.
These hospitals therefore did not submit self-assessment or complete audit tool pro-formas, nor were they visited.

Disclaimers were accepted by hospitals on the basis of the following:

Hospitals had to provide confirmation of their position in relation to retained organs as a result of post-mortem examination practice in hospitals; the disclaimer had to be completed and signed off by hospital Chief Executives/General Managers.

The requirement was to confirm that a senior member of hospital staff had undertaken a physical search of the hospital site.

Following this search the hospital Chief Executive/General Manager:

- Confirmed that the hospital does not have any currently retained human organs as a result of post-mortem examinations.
- Confirmed that the hospital has not carried out post-mortem examinations since 2000.
- Confirmed that no human organs retained at post-mortem examination have been disposed of in this hospital since 2000.

Finally, s/he confirmed that no organs, retained at post-mortem examination, had been received, sent or used at that hospital for teaching, training, or research or sent to pharmaceutical companies since 2000. (This does not apply to tissues or organs retained through surgical procedures).

Any caveats to the answers provided had to be explicitly stated.

The Network Manager/Chief Executive/General Manager of the hospitals was required to sign off this document.

Details of those hospitals, which submitted disclaimers, are set out in Annex 2. Site visits to Hospitals, that did not provide disclaimers, provided no indication or evidence that Post Mortem Examinations (other than

State Post Mortem Examinations) were being carried out or that were any retained organs on sites which had provided disclaimers. On one site visit, to a hospital which had not provided a disclaimer and was therefore was routinely audited, it was indicated that a visit to a hospital that had provided a disclaimer was required. This hospital was visited and it was verified that the status of the disclaimer provided was correct. (see Mid Western Regional Hospital, Nenagh)

Adelaide and Meath Hospital incorporating the National Children's Hospital (AMNCH/Tallaght)

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**30** it is not know what the division between HPM and CPM is, log provided by the hospital did not clearly differentiate.	**4**
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	**14** organs disposed of **11** from HPM cases and **3** form CPM cases at AMNCH (of which 2 were by clinical waste with the family's agreement.)
Post Mortem Post 2000	**7** unidentifiable *(there are no records pertaining to their identity or origin)* fetuses were disposed of by burial. **85** organs have been disposed of at AMNCH. These figures include disposal for Naas General Hospital *disposed of 17 organs retained at CPM on behalf of Naas Hospital.*

Policy and practice

- AMNCH status is validated with a clear document trail.
- Policies and procedures are *excellent*.
- All documentation, logging and tracking were to a *very high standard* and fit for purpose.
- There was a full and complete set of policies and standard operating procedures in place and all were properly version controlled and up to date, ratified and an established part of practice.
- The hospital has also considered its policies in the light of current national guidelines for the storage, removal, retention and disposal of organs and this documentation has been formally reviewed and revised to comply with national policy.

AMNCH should be commended for the high standard of their policy and procedures and are exemplary.

Record management and tracking

- The records, documentation and logging systems for the retention of organs at post-mortem examination were also thorough and maintained to a high standard and all on electronic format.
- Incidents of poor information giving would be formally investigated but only if the relative made a complaint. These systems are integral to the hospitals clinical governance system. However the hospital state that they use their adverse incident reporting system to monitor instances in which the processes surrounding the management of the storage, use, removal, retention and disposal of organs, of consent and of the support of bereaved relatives, were poor.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- A doctor is always involved in seeking consent, although other professionals may be involved as necessary. Ultimately the doctor is responsible for delivering information and seeking written consent to post -mortem examination. *Good practice.*
- Suitable consent form was observed.
- The hospital indicated that the people who may be involved in the process of seeking consent had received training in obtaining informed consent to post–mortem examination. *Good practice.*
- The hospital also indicated that those doctors who may be involved in seeking consent, but who were not qualified to conduct the post-mortem examination, should have seen a post–mortem examination being undertaken. *Good practice.*
- The process for seeking consent to post –mortem examination is set out in the Medical and Pathology Standard Operating Procedures.
- Consent training is therefore embedded within the hospital system with clearly defined roles and responsibilities amongst staff. *Good practice.*
- Comments: At AMNCH a very basic consent form and information leaflet for the donation of brains to Beaumont brain bank for research purpose was observed.

Storage and disposal of organs

- Appropriate storage of organs was observed, as was the sensitive disposal of organs either by burial, or cremation as per the wishes of the next of kin. *In line with national policy and is good practice.*
- AMNCH also dispose of organs for Naas General Hospital. Naas General Hospital do not consider that they have appropriate facilities for the storage or organs removed at post-mortem examination. Therefore the organs are transferred to AMNCH for examination, storage and disposal. The transfer is carried out appropriately through the laboratory.
- Naas General Hospital retains responsibility to inform and ascertain their wishes from the deceased relatives regarding disposal when the examination of organs is complete or the coroner has agreed their disposal. Tracking and documentation in this regard is *excellent.*

Bereavement support services

- A number of weeks after a death in the hospital, the Pastoral Care Team send a letter of condolence offering support, a leaflet entitled Grief, What Can Help, and contact numbers for bereavement support. A team member is a trained suicide counsellor and support counsellor. Every other month families are invited back to the hospital for a Bereavement Service of Light. *Good practice.*
- A multidisciplinary team is responsible for the management of bereavement services; pathology/mortuary are staff under the management of the consultant histo-pathologist, together with those listed above are responsible for the delivery and quality assurance of bereavement services. *Good practice.*
- The hospital has considered its policies in respect of current national guidelines in the provision and delivery of bereavement services, and is currently being reviewed. *Good practice.*
- The mortuary has a Chapel of Rest or viewing area where relatives may view the deceased. The area contains removable religious symbols. The viewing area is accessible to wheelchair users and other people with impaired mobility.
- The Pastoral Care Team is available 24/7 for pastoral needs of the bereaved. The hospital has family rooms and the pastoral care offices and quiet rooms are used for relatives where sensitive conversation can be held respecting the need for privacy and dignity of the patient, relatives, and carers. *Very good practice.*

Information leaflets and support

- There are a number of excellent leaflets relating to the post-mortem examination. *Good practice*
- *The above is an example of good service provision.*

Areas for improved focus/action

- It is noted that there is no review and/or audit process in place; the service would be enhanced if such a service were introduced.
- Production of a bereavement pack is suggested.
- There should be standard operating procedures (SOP's) introduced with regard to the receipt and disposal of organs for Naas Hospital and the retrieval of brains for research for Beaumont Hospital.

Beaumont Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A **Pre 2000**	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	**3**
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult		**98** organs	**40** organs from **38** cases (CJD or query CJD) **30** organs **26** cases research
Children	0	0	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	**0**
Post Mortem Post 2000	**782** organs disposed of post 2000 **1** identifiable fetus buried as per families wishes

Policy and practice

- Documentation is varied within the organisation; certainly documentation relating to the mortuary and post-mortem examination practice is weak.
- There are a number of forms such as the mortuary information sheet that demonstrate proper document control, in contrast to the mortuary policy, which is not version controlled or ratified.

Record management and tracking

- Mortuary logs books on site were quite poor.
- There appears to be a dual process of recording, a manual and excellent detailed electronic logs of retained organs, which were provided upon request. When there are 2 separate data collection sources (in this case there were 3, it is easy for errors to be made).
- Research donation log was not complete and did not document the consent or discussion with the person; at the time of the visit the consent forms could not be located. On a subsequent visit all electronic logs were updated.
- Do monitor service by incident reporting and also through bereavement programme - *very good practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- The post-mortem examination consent form lacks detail, although it is a version-controlled document. The form provides for an organ to be retained with consent for research and education purposes. However it does not mention that an organ or organs may be retained for further diagnostic purposes and therefore does not provide an option for relatives to give consent to this.
- An attending medically qualified individual' seeks consent.
- There is no mention of training with regard to the seeking of consent as the essential condition for the retention of organs following a hospital post-mortem examination or for the retention of an organ for research purposes. There is also a section covering verbal consent within documentation, including consent taken over the phone, even though *ERHA guidance in 2002 stated that verbal consent was not valid consent.*[9]

Storage and disposal of organs

- Burial of retained organs is in a burial plot owned by Beaumont Hospital. Burials are appropriately recorded and there is a complete audit trail from the post-mortem examination through to the burial of the retained organs.
- The returns process is of a *high standard* with regard to the return of organs.
- The storage of organs is poor and inappropriate with regard to CJD cases; located on the post-mortem examination table in the isolation room.
- Others (i.e. the research brains) were in non-lockable cupboards in the storeroom; and others were stored at a different part of the hospital where the packing for sensitive disposal takes place.
- The information surrounding this process of cremation for interment is unclear and suggests that the relatives may wish to collect ashes from such an act of cremation. There is debate internationally about this. However, there is no documentary evidence to suggest that there are any residual ashes from a cremated organ. (See Section B).

Bereavement support services

- Bereavement services at Beaumont are of a *very high standard. Excellent practice observed.*
- Structured bereavement programme and monitored effectiveness of delivery of service in relation to information and processes related to organ retention. *Very good practice.*
- Provision of a bereavement outreach service. *Excellent service.*
- The provision of meetings for families and parents groups is *excellent practice.*
- Multi disciplinary team as opposed to one individual, *excellent* embedded service.

Beaumont Hospital should be commended for its high standard of their bereavement service and the delivery of an exemplar adult bereavement service.

Information leaflets and support

- The information sheet regarding autopsy tissue does mention the retention of organs at post- mortem examination; *this is good practice.*
- Information is available concerning the donation of organs following coroner's post-mortem examinations and there is a release form to enable blocks and slides to be released for disposal following consented laboratory examination such as histology.
- Excellent bereavement booklet (*produced by Beaumont and used in many hospitals across the State - an excellent piece of work and an exemplar*).

Areas for improved focus/action

- Review disposal information regarding cremation of organs.
- Document revision and control.
- Review internal logging, tracking and audit of retained organs.
- Production of CJD polices and standard operating procedures.
- Review referral process of brains from other hospitals for examination. There is a need to review and produces standard operating procedures between referral hospitals and the logs need to be more accurate. The HSE should promulgate the need for this standard operating procedure to be in place with all referring hospitals.
- Review compliance with external report previously undertaken; at the time of the 3rd audit visit the audit team were informed that action was being taken.
- Review consent form and appropriate related training.
- Review storage arrangements for organs.
- There is a need to review and upgrade the some of the facilities/equipment and review housekeeping i.e. dirty/clean areas within the mortuary.
- There is a need to review the arrangements for Personal Protective Equipment (PPE) and the Control of Substances Hazardous to Health (COSHH).
- It is apparent that the neuro-pathologists are stretched with their own workload and carrying out visits to other hospitals as well as having organs referred to them. This is an area for improved focus and additional support is needed – both secretarial and technical. With regard to the above, staffing levels

should be reviewed, with consideration given to the appointment of a senior mortuary technician as mortuary manager to implement much of the above.

Cavan General Hospital

All the post mortem examinations on behalf of Cavan and Monaghan Hospitals are carried out at Cavan Hospital and all organs retained from these are stored at Cavan.

Validation Status –*Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**1**	0	0
Children	0	0	0
Fetuses	**9**	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	**9** organs CPM **2** organs HPM **99** fetuses have been disposed of.

Policy and practice

- The policies and standard operating procedures in place were comprehensive and were all excellently compiled and version controlled.
- The respondent indicated that the hospital had considered its policies in respect of current national guidelines concerning organ retention but at the time that the audit was completed not all the policies had been formally reviewed and/or revised. This was to be completed in the next 6/12 months.
- What was evident from interviews was that the policies are embedded within the organisation. *Excellent practice.*

Record management and tracking

- The records were of a reasonable standard; however, the lack of trained mortuary staff or office facility in the mortuary makes the function difficult. Hardback recording was also in need of improvement.
- The hospital monitors the effectiveness and retention of information disseminated to the bereaved at the time of a post-mortem examination, and provided evidence of this in the supporting portfolio of evidence.
- There is also a process for investigating circumstances where the quality of information provided to bereaved relatives was poor and any employee who has access to the reporting policy and forms was able to report incidents. The Risk Management Department would then investigate the incident, possibly conducting case reviews with the emphasis on learning and quality improvement. Upon completion of any investigation the Risk Management Department would provide report analysis through the information officer based in the department. *Good practice.*
- The hospital also monitors incidents where the processes surrounding the management of retained organs are poor, including support to bereaved relatives, through the procedure for adverse incident reporting. *Good practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- Guidelines in relation to obtaining consent to clinical treatment in an acute setting are in place.
- The HSE Dublin North East presented a comprehensive conference in relation to this in February 2007 with an accompanying CD and leaflet. Although the agenda did not cover post-mortem examination consent, it is clearly demonstrated that there is suitable training with regard to seeking generic consent.
- A doctor always is the person to seek consent, usually accompanied by a nurse or a midwife.
- The consent form is appropriate.

Storage and disposal of organs

- Storage of organs is appropriate.
- With regard to hospital post-mortem examinations and the retention of organs the family's wishes are sought with regard to choice regarding the mode of disposal.
- The hospital's policy states that residual tissue/organs retained for coroner's post-mortem examinations shall be disposed of by incineration once the death certificate has been issued i.e. following the inquest if applicable. However the audit team are informed that the NOK are informed of this as part of good communication. The hospital also states that incineration as a mode of disposal 'is an option by consent'; in contrast a further statement from the hospital states that 'no organs have been disposed of by incineration post 2000'. Another statement from the hospital states 'If an organs is required for further examination as part of a PM, then the families are consulted directly through the coroners office or via the relevant consultant and asked for guidance in the manner of disposal. ***The practice of incineration is wholly unacceptable. It should not be offered to families even with consent. Cremation should be offered as an alternative. (see note below)***
- Hospital Policy goes on to say that should any next of kin indicate that they wish to have retained tissue returned to them, that the clinicians must arrange this in conjunction with the pathologist. Otherwise residual tissues/samples/organs should be disposed of in accordance with current hospital policy (stated above).

Bereavement support services

- An excellent care pathway is in place but there is a need for staff training. The hospital has considered its policies in the provision of bereavement services although not all have been formally reviewed and revised. The hospital plans to review and revise within 6 months.
- There is an understanding of pressures on staff in dealing with the dying and deceased and how traumatic it can be.
- Bereavement issues are taken seriously at senior management level.
- There are dedicated relatives' rooms on the ward area and close to the ward area as well as a general relatives' room. There is a viewing room containing removable religious symbols, which, together with sacred texts, can be provided on request.
- The viewing area is accessible to wheelchair users.

Information leaflets

- There is a good range of leaflets to distribute to bereaved relatives as part of an excellent bereavement pack.
- Cavan is part of the 'Hospice Friendly Hospitals' programme and therefore has, specific to this project, supplementary leaflets for the bereaved; as a result of this there is a comprehensive hospital leaflet on registering a death.
- There is also a specific bereavement pack should a child die at the hospital, again containing a comprehensive array of leaflets. Good practice.

Areas for improved focus/action

- Incineration of organs is not acceptable practice and should cease with immediate effect as per 2002 ERHA guidance.[9]
- Training for mortuary staff. There is no qualified technician. Staff support for the pathologist is needed urgently.

- Office housekeeping and management within mortuary would be aided if a full time technician were in post.
- The mortuary facilities are in need of modernisation.

Note: (There were a number of specific issues highlighted by the Audit team to the HSE that required immediate action ahead of the publication of the report. One of the issues highlighted was the practice of the disposal of organs by incineration at Cavan General Hospital. The following has been noted by the audit team in relation to the specific issues raised.)

- The Hospital has informed the HSE that the last organ disposed of by incineration by Cavan General Hospital occurred in November 2007.
- The hospital advised the HSE in January 2009 that it had directed that the practice of disposal of organs by incineration should cease and hospital policy would be amended to reflect this.
- The Hospital Manager confirmed to the HSE on 12th June 2009 that the practice of disposal of organs by incineration has ceased.

Children's University Hospital (CUH) - Temple Street

As is evident from the title the hospital is a children's hospital and therefore returns provided by the hospital are confined to children only. That is to say that there are no data for pre-viable fetus', stillborn babies, perinatal deaths or adults.

Validation Status - V*alidated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	**5** organs	**25** organs	(of which **2** are for research purposes)
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	**124** organs had been disposed of. (**26** removed at HPM) (**98** removed at CPM)

Policy and practice

- The hospital has considered its policies in respect of current national guidelines for the storage, removal, retention and disposal of organs. Policies have been formally reviewed, accepted by the Senior Management Team and ratified and fully implemented and are all version controlled. *Exemplary standard.*
- It is evident from meeting staff that the policies are truly embedded within the ethos of the organisation. *Exemplary*.
- The Head of Pathology and the Chief Executive Officer sign off the policies and standard operating procedures. This is an organisationally sound process exhibiting Senior Executive engagement. *Excellent practice.*
- *The documentation, policy and procedures at the hospital are excellent and are of an exemplary standard.*
- The consultant histo-pathologist has corporate responsibility for the delivery and quality assurance of mortuary services and organ retention issues.

Record management and tracking

- There are extremely comprehensive databases for logging and tracking removed and retained organs. *Exemplar standard.*
- Clerical procedures surrounding the post-mortem examination process are exemplary. *Excellent practice.*
- The hospital monitors the effectiveness and retention of information disseminated to bereaved relatives at the time of post-mortem examination, and has conducted an internal assessment of the service (2004) and a review of post-mortem examination documentation (2006). *Excellent practice.*
- If information surrounding post-mortem examination were badly delivered to relatives the complaints officer/Risk Management Committee would investigate this as an adverse incident. The person responsible for reporting the incident is identified in the hospital adverse incident reporting policy but the respondent indicated that there were currently no adverse incidents relating to poor information

giving. Lessons learnt from any adverse incident reported would be fed back into the organisation via the Risk Management Committee as part of the hospital's clinical governance arrangements.

- The hospital uses the same adverse incident reporting arrangements to investigate incidents concerning the management and disposal of retained organs; consent to post-mortem examination; support for bereaved relatives; or where it was considered that the body of a deceased patient had been handled inappropriately. *Good practice.*
- There was evidence of a comprehensive post-mortem examination audit in 2000, 2001 and 2004; this is excellent practice.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

The above practices should all be considered excellent and of an exemplary standard. The hospital has excellent disposal records and database and should be considered an exemplar site.

Communication with families - Consent

- A doctor is always involved in seeking consent and is ultimately responsible for obtaining written informed consent to post-mortem examination.
- Occasionally the pathologist might be involved in seeking consent, but the process would never involve any other health professionals i.e. nurse, midwife, social worker, chaplain or similar health professional.
- The consent form for post-mortem examination was appropriate.
- Doctors do receive training in seeking consent as part of their induction process.
- The doctors seeking consent for post-mortem examination would not normally be qualified to conduct a post-mortem examination and the hospital was unable to confirm that each of the doctors taking consent would have seen a post mortem being conducted.
- The process for obtaining consent to post-mortem examination was described:

> *'The Consultant or Senior Registrar in charge of the deceased child will obtain consent in hospital cases. In Coroners or B.I.D. cases the emergency consultant will inform the family of the post mortem requirement and inform them of the possibility of organ retention and then asks them to sign an acknowledgement form'* .[11]

- The hospital has trained doctors to seek consent to post-mortem examination and to provide full information about post-mortem examination practice.
- As noted above, work undertaken to review current documentation and practices has identified that:

> *Documentation for consent is discussed at NCHDs by the Pathologist and Emergency Consultant. The Bereavement Co-ordinator has training sessions with senior nurses regarding post mortem information each quarter.' 'Multidisciplinary training days cover post mortems. The training needs of medical staff need to be further expanded'* .[11]

- The service delivered by the Children's University Hospital is a multidisciplinary service and *can only be described as exemplary.*

Storage and disposal of organs

- Organs are appropriately and safely stored in lockable cabinets in the post-mortem examination suite. *Good practice.*
- An excellent process from documentation thorough to family involvement and choice with regard to the disposal of organs is in place. *Excellent exemplar service*

Bereavement support services,

- The Head Medical Social Workers and Head Chaplain are responsible for the management of bereavement services and together with the consultant histo-pathologist are responsible for the delivery and quality assurance of bereavement services. *Good practice.*

- Dedicated relatives' rooms are available with a selection of toys for young children and an external telephone line. An excellent viewing area is available containing removable religious symbols and sacred texts can be provided on request. The area is wheelchair accessible. Chaplains provide 24 hours cover and the night sister deals with families when the chaplain has left the hospital. *Excellent practice.*
- Each ward has a bereavement pack and these arrangements are discussed at staff training days. *Good practice.*
- There is a Bereavement Coordinator within the hospital; this is an exemplary role in the provision of training, education and coordinating services.
- The chaplaincy service is extremely comprehensive and a very good remembrance service is offered, with a huge amount of detail, including a tree with rocking horses hanging from it, each with a child's name on. There are also flowers and candles and a display for the siblings. *Excellent service provision.*
- It was clear that the chaplaincy team had spent a good deal of time on this as well as on the provision of a multi faith prayer room. *Exemplary standard and excellent service provision.*
- There are interfaith lunchtime talks, which are well attended.
- There is a bereaved parents' support group, which is very good practice. The programme has been an integral part of the bereavement support offered by the hospital since the mid 90s; these include bereaved parents having input to policy. *Exemplary practice.*
- The hospital has considered its policies in respect of current national guidelines in the provision of bereavement services; these were reviewed and revised, ratified and fully implemented in 2006. *Excellent.*

Information leaflets

- The hospital should be commended for its excellent service provision.
- There is plethora of support information and bereavement booklets and literature, all of an extremely high standard.
- A bereavement information pack is provided including an expression of condolence, information about common grief reactions, contact details for hospital chaplaincy, hospital bereavement support services, local and national bereavement support agencies, ward telephone number hospital switchboard number. Also provided is information about registering the death and the death certificate, together with an explanation of what happens to the deceased's body after the relatives leave the hospital. *Excellent.*

Areas for improved focus/action

- There are no staff specifically trained or any particular additional process in place for providing information in relation to the retention of organs at post-mortem examination for an unexpected death where a post-mortem examination is ordered by the coroner. This should be picked up as this is a national problem.

Connolly Hospital, Blanchardstown (CHB)

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**2**	**6**	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	0
Post Mortem Post 2000	**11** organs (see disposal)

Policy and practice

- No policies and procedures were available on the first audit visit except for a 'last offices policy'.
- On return for the second visit, policies were being designed with the assistance of another hospital.
- There is a good relationship with the coroner but no written standard operating procedure on first visit but this was being rectified by the second visit.

Record management and tracking

- There is no organ retention register; again this was being rectified.
- However, it is evident that there is a record of all organs removed and retained but the tracking is not easily followed or accessible.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- The hospital consent form, at the time of the visit, needed to be refined.
- A doctor seeks consent always and sometimes a social worker will assist in this process.
- No training is given to doctors other than that received during their medical training.

Storage and disposal of organs

- The organs are stored appropriately in the laboratory.
- However, pre Madden (2003/2005) 3 organs were incinerated (**2** with consent for disposal and **1** on health and safety grounds) there were **3** further organs disposed of pre 2005, the hospital inform the audit team that 1 organ was disposed of due to possible infection and the family were informed. Regarding the remaining 2 organs there is no record of how the organs were disposed of. ***The practice of incineration is unacceptable by today's standards and ceased at the hospital in 2005.*** *(see note)*
- The remaining organs were sensitively disposed of either by burial or cremation.
- The hospital informed the audit team that the next of kin are offered return of the organ for burial or burial in a designated hospital plot.

Bereavement support services

- There was a good viewing and removals area. *Good practice.*
- There was a spacious and appropriate chapel and chaplaincy service for the bereaved when needed. *Good practice.*
- The viewing area has removable symbols and is wheelchair accessible. *Good practice.*

- The social work department are available to bereaved families where the family are known to the social work department and those brought in dead, the families are referred to the social work department for support.
- Connolly Hospital is participating in the 'Hospice Friendly Hospital' programme.

Information leaflets

- There was evidence of some national information leaflets/ support information for the bereaved and a comprehensive leaflet attached to the consent form. Also the Beaumont bereavement booklet is distributed.
- There is a form that informs relatives that organs will be disposed of by standard practice; although the form mentions cremation in the next sentence it does not make clear what standard practice means. However in coroner's cases where an organ is retained an information leaflet is given to families with regard to their chosen method of sensitive disposal for an organ.

Areas for improved focus/action

- The recording and tracking of organs (underway).
- Clear information leaflets.
- Review of bereavement services.
- Review of Polices and procedures (underway).
- Review facilities for sensitive conversations i.e. dedicated bereavement room.
- Training with regard to seeking consent to post-mortem examination for Doctors.

Note: (There were a number of specific issues highlighted by the Audit team to the HSE that required immediate action ahead of the publication of the report. One of the issues highlighted was the practice of the disposal of organs by incineration at Connolly Hospital. The following has been noted by the audit team in relation to the specific issues raised.)

- The Hospital informed the Audit team that the disposal of organs by incineration at Connolly
- Hospital ceased in 2005
- Connolly Hospital confirmed to the HSE on the 6th April 2009 that the practice of disposal of organs by incineration ceased in 2005.
- In a letter dated 10th June 2009 to the HSE the Hospital has confirmed that all retained organs are now disposed by burial or returned to the next of kin in line with their wishes.

Coombe Women's Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	**24** (***historic museum collection***)		
Children			
Fetuses	**10** pre-viable fetus' which are unidentifiable *(there are no records pertaining to their identity or origin)* and **2** identifiable fetus' (***historic museum collection***)		
Comments: These **36** organs are an ***historic museum collection***, which had previously been declared to the Dunne and Madden Inquiries.			

Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	**2**	**1**	0
Fetuses	**40** identifiable pre viable fetus	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	**51** pre-viable fetus' disposed of by burial
Post Mortem Post 2000	**65** pre-viable fetus' had been sensitively disposed of by burial post 2000.

Policy and practice

- The hospital has given particular consideration to its policies in relation to national guidelines in respect of organ retention; all been formally reviewed and were awaiting ratification, which was anticipated within 3 months of the audit taking place. *Good practice.*
- The hospital has a wide range of documents of an exemplary standard, and there is a policy or standard operating procedure for all practice.
- All documents are fully version controlled. The hospital should be commended for their exemplary policies, procedures and the organisational embedding of these.

Record management and tracking

- All logs are electronic and held in the mortuary and the laboratory. *Excellent practice.*
- All documents are electronically managed and version controlled with a regular 6 monthly check that all documents are up to date on ward paper portal. *Good practice.*
- All documents are live on real time and can be viewed by those with access at any time. They are backed up 4 hourly. *Good Practice.*
- The information systems are good; impressive and managed effectively. Systems are in place to monitor the effectiveness and retention levels of information disseminated to bereaved families at the time of the post-mortem examination. These systems include regular review of the patient information leaflet as part of the document control system and periodic discussion of patient information at the monthly perinatal mortality meetings. *Good Practice.*
- Discussion with individual clinicians also occurs on a regular basis. *Good Practice.*
- Incident reporting is seen to be integral to the hospital clinical governance system for which the Master is currently responsible. *Excellent practice.*

- There is an excellent tracking system from the beginning to the end of the process - from when a patient dies through the consent process or the call for a coroner's post-mortem to the eventual funeral. It is sufficiently fine-tuned to ensure that that a post-mortem examination would not take place without all papers being in place. *Standards excellent.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families -Consent

- Only consultants and junior doctors seek consent for post-mortem examination.
- The audit team was informed that the doctor is usually qualified to conduct the post-mortem examination; if not, they will have witnessed a post-mortem examination.
- There was no formal training with regard to the above, although the hospital intended to implement such training in January 2008.
- Most post-mortem examinations performed in the hospital are consented post-mortem examinations.
- The consent form is appropriate.
- The above is *very good practice.*

Storage and disposal of organs

- All sensitive disposals are by burial. *Good practice*.
- Organs were stored appropriately. *Good Practice*.
- The storage/disposal of the museum collection needs to be reviewed.

Bereavement support services

- There is a multi disciplinary team approach adopted with regard to bereavement services in the hospital *Good practice.*
- A professional counselling service is available to bereaved families in addition to a chaplaincy service. The chaplaincy services are ecumenical and multi faith and also encompasse non-religious and humanistic 'chaplaincy' services. *Good practice*.
- Coombe also have a remembrance service. *Good practice*.
- The medical social work department is available to bereaved families; the degree and length of contact is variable depending upon the situation. This service also extends to subsequent pregnancies if required. *Good practice.*
- There are no dedicated relatives' rooms. Private spaces are created within busy clinical areas. Consultations with relatives are scheduled for off-peak times, between clinics or after hours. However, there is a dedicated overnight facility on St Gerard's Ward (gynaecology) for bereaved parents. If a second room is needed a single room is made available on the ward and also in the delivery suite for bereaved mother and partner in labour.
- There is a viewing area with removable religious symbols and sacred texts are available. The area is accessible to wheelchair users. *Good practice*.

Information leaflets

- Overall the provision of information to mothers or parents following miscarriage or where a baby is stillborn *is excellent.*
- The hospital provides a bereavement information pack including an indication of common grief reactions, contact details for the hospital chaplaincy, hospital bereavement support services, local and national bereavement support agencies, and details about registering a death. A remembrance-blessing card is also sent. *Good practice.*

Areas for improved focus/action

- A decision must be taken with regard to the museum specimens, especially the unidentifiable fetus', with regard to their continued preservation or sensitive burial, as it is likely there was no consent for such retention. They are currently not on display but are boxed awaiting a resolution being reached and guidance being issued following this report.

Cork University Hospital and Cork University Maternity Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	**3** (CUH)	**0** (CUH)	**0** (CUH)
Children	**0** (CUH)	**0** (CUH)	**0** (CUH)
Fetuses	**0** (CUH)	**0** (CUH)	**0** (CUH)
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**0** (CUH)	**0** (CUH)	**0** (CUH)
Children	**0** (CUH)	**0** (CUH)	**0** (CUH)
Fetuses	**0** (CUH)	**0** (CUH)	**0** (CUH)

Comments: (CUMH) has **1** specimen retained.
A return visit was needed to CUH; there were 2 *issues* on the first audit visit. (1) A detailed internal review took place to identify the origin of an unidentified organ and it was positively identified. The family were contacted in this case. Measures have put in place locally to ensure that an appropriate system of audit and evaluation has been put in place. (2) A query in relation to logging of CJD organs arose. It was found that a suspected CJD organ was disposed of in error and another organ retained in its place. This issue was resolved satisfactorily and the families concerned were notified.
Both issues were investigated and the audit team was satisfied with the outcome of the investigations.

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	74 organs disposed of in 54 cases at HPM and 37 organs disposed of in 25 cases in CPM. Included in this figure is **6** organs retained for research at Our Lady's Children's Hospital, Crumlin (from 2 State Pathologist cases) and 1 at Beaumont Hospital.
Other	The records of the State pathologist were made available to the audit team but figures are not included as outside the terms of reference.

Policy and practice

- CUH had reviewed and revised their policies to comply with national standards. Furthermore these policies had been accepted at Senior Executive level and ratified accordingly. *Good practice.*
- CUH had very good documentation, polices and standard operating procedures in place with regard to post-mortem examination; these were all fully version controlled. *Excellent practice.*
- Maternity services, CUH has excellent documentation underpinned by careful document control which includes version control; date; document numbering; record of who approved the document; approval date; issue date; review date; and authors. *Excellent practice.*
- These policies are in addition to the policies and procedures, which support the operational management of the hospital and comprise parts of the overall clinical governance system. The clinical governance system at CUH and Maternity services, CUH is well integrated and there are strong information systems in place to inform both staff and bereaved parents about services, which are available to them. *Good Practice.*
- Policies have evolved over the years and the procedure allows the consultant pathologist to deal personally with families/relatives of the deceased. *Good Practice.*

Record Management and Tracking

- CUH had very good logs in the form of hardback registers within the mortuary.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

- Each hospital reported that the effectiveness and retention levels of information given to the bereaved at the time of the post mortem examination were monitored via the complaints process. Additionally Maternity services, CUH also said they received feedback from staff through the Bereavement and Loss Committee. They also had a trigger mechanism through the clinical incident reporting form and regular meetings were in place with the histo-pathologist where issues around post-mortem examination could be discussed. Furthermore there is also a Miscarriage, Stillbirths and Neonatal Deaths Committee to monitor the continuous improvement of work in this area. *Good practice.*
- Once again, each organisation had systems in place to monitor the information given to bereaved relatives around post-mortem examination, which allowed them to identify occasions when the quality of information giving was poor. However, each organisation relied on the complaints process and therefore would only identify a problem if it were reported.
- In each organisation there was a mechanism in place to ensure lessons learned were fed back into the organisation, and the systems described were integral to the clinical governance structure. *Good practice.*

Communication with families –Consent

- Each hospital reported that they had trained specific staff to obtain consent and provide full information about post-mortem examination practice.
- CUH indicated that the doctor was always involved in taking consent and may sometimes be accompanied by a nurse. The Doctor was always the person responsible for finally obtaining written informed consent to post-mortem examination At Cork University Hospital:

  'the Consultant Pathologist comes to speak to the NCHDs at induction regarding post mortem practice' .[12]
- Whilst at Maternity services, CUH:

  'Senior Medical Staff obtains consent, i.e. senior registrar or consultant. Staff are kept up to date on consent procedures by the risk manager. Information sessions are held for NCHD's '.[12]
- At Maternity services, CUH the Doctor was always involved with obtaining consent but the process always involved other professionals. This would always include the pathologist, nurse, midwife and usually a chaplain. They may also include a social worker although this was not often the case.
- The CUH consent form is appropriate.
- There is, at Maternity services, CUH a consent form for the pathological examination of fetuses under 16 weeks and also a consent form for a hospital-arranged burial, together with a number of very helpful checklists in relation to: Late Miscarriage 16-23 weeks, Recurrent Miscarriage, Pre 16 week miscarriage and Intra uterine deaths/stillbirths.

Storage and disposal of organs

- The storage of organs is appropriate at CUH.
- There is a state pathology mortuary on site as well as a hospital mortuary, with a state pathologist based in an office at the hospital.
- In State cases' organs are stored on the hospital site and the state pathologist also uses the hospital mortuary/post-mortem examination suite. All records were made available to the audit team.
- Disposal is appropriate.

Bereavement support services

- Maternity services, CUH has a bereavement midwife to provide information and support to mothers/parents following the loss of a baby.
- There is a very impressive role of bereavement and loss midwife specialist and there is also access to perinatal liaison mental heath services.
- There is an Intensive Therapy Unit relatives' room, and day rooms on wards and sister's offices are available for use by relatives, including an external telephone line and a selection of toys for children.
- There is a viewing area with removable religious symbols and sacred texts can be provided on request. The viewing area is accessible to wheelchair users.
- All bereaved relatives have access to bereavement services and the quiet room.

Information leaflets

- At Maternity services, CUH there are a number of information leaflets and booklets provided for bereaved parents. Some are produced by the hospital (of which some refer to local support services) and others are information leaflets provided by national organisations. The information sheet for post-mortem examination is extremely detailed and does mention the possible retention of a whole organ or organs.
- With regard to information which may need to be provided following a coroner's post- mortem examination at Cork University Hospital, the:

  'Consultant Pathologist personally informs the family/relatives that she is carrying out a post mortem. Once complete she contacts the family/relatives personally and liaises with them over returning of body or a hospital funeral.'[12]
- CUH subsequently indicated that the above practice only takes place in the event of organ donation and that the treating physician would liaise with the family in all other instances.
- The hospital provides a bereavement information pack including an expression of condolence; advice about registering the death and contacting a funeral director; an indication of common grief reactions; together with contact details for local and national bereavement support agencies, hospital chaplaincy, hospital bereavement support services, hospital switchboard and ward.
- There is an abundance of leaflets in the bereavement pack - from nationally available documents to locally produced leaflets, There are also booklets for the family to put photographs, footprints, hand prints, and locks of hair into as mementos.

Areas for improved focus/action

- Hardback registers in mortuary would benefit from being electronic as are the laboratory registers.
- There is a need to ensure that all disposals are recorded appropriately.
- Review recording process including the logging of referrals to other hospitals.
- The recording of the disposal of organs should be reviewed.
- Anatomical pathology technicians are employed by the hospital but also have responsibilities to the State pathologist.

Galway University Hospitals (University Hospital Galway and Merlin Park University Hospital Galway)

No post mortem examinations are performed at Merlin Park Hospital and therefore no organs are retained there.

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	**2**	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**14**	0
Children	0	0	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	**75** organs were disposed of post 2000.
Post Mortem Post 2000	• **100** organs • **217** fetuses had been disposed of.

Policy and practice

- The hospital has a variety of policies that are well presented and comprehensive. Clearly, at some point in the past the hospital has given time and effort to developing and implementing a range of policies and standard operating procedures and all versions were controlled. However, it is evident that most of the documents listed above are now quite dated and generally are no longer subject to effective version control. Most policies are therefore well overdue for revision and there is a need for the application of more robust version control.

Record Management and Tracking

- Comprehensive hardback registers in use.
- Once reported, incidents of poor information giving are investigated by the senior hospital management/consultant or by nursing management. The incident is reviewed and any risk factors are identified with the investigating officer making recommendations to prevent recurrence. The family are invited to meet the hospital management/consultant or Director of Nursing to discuss the results of the investigation and subsequent recommendations. Any lessons learned are fed back into the organisation via the Risk Management Committee. *Good practice.*
- Whenever it becomes apparent that information regarding removal/retention of organs has been poorly delivered, or the body of a deceased person has been handled inappropriately, this is investigated as an adverse incident with both the hospital management and the appropriate consultant being contacted. *Good practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families –Consent

- *"A senior doctor – either a consultant or a registrar – is always involved…'.* with obtaining consent to post-mortem examination; no other professional was identified by the hospital as being involved in this process. The hospital indicated that doctors were given training in obtaining consent to post-mortem examination as part of induction training, and that they were all competent to conduct the procedure.

- The hospital has not trained specific staff in obtaining consent to post-mortem examination and providing full information about post-mortem examination practice but relies on the appropriate hospital policy being available in all areas and being provided to staff as appropriate.
- Staff are made aware of the policy through a variety of means including internal training and education programmes.
- Most of the hospital's pathologists will not speak with relatives/next of kin. The Pathologists view is that consent for post-mortem is best obtained by the clinical team that cared for the patient.
- The consent form was appropriate.

Storage and disposal of organs

- The storage of organs was appropriate.
- The disposal of organs was appropriate

Bereavement support services

- The Bereavement Liaison Officer is responsible for the management of bereavement services. *Good practice.*
- There are dedicated relatives' rooms on the ward area and in a separate building on the hospital complex. The ward sister's office and other offices are also regularly used. *Good practice.*
- A viewing area is available with removable religious symbols and sacred texts are available on request. The viewing area is accessible to wheelchair users and plans to upgrade the facilities have been finalised. *Good practice.*
- Inpatient remains are kept on the ward until family members have viewed the body.
- The Chaplain is present at the time a deceased is viewed if appropriate.
- Merlin Park Hospital has an excellent care for the elderly facility with dedicated rooms for the dying and for spending time with the deceased. *Excellent facility.*

Information leaflets

- There is a helpful information leaflet available for families and others following the death of a patient.
- The hospital provides bereavement information including an expression of condolence; an indication of common grief reactions; contact details for local bereavement support agencies and the hospital bereavement service; and advice about funeral directors, the death certificate and registering the death. *Good practice.*

Areas for improved focus/action

- Review policies and standard operating procedures.
- Review the use of electronic logs.
- The hospital identified that the service currently provided by the Bereavement Liaison Officer was only available Monday to Friday with no locum cover for annual leave.
- Review bereavement services provision.
- Management of referred organs should be reviewed.

Kerry General Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	**4** (pre viable) (awaiting burial – recent cases)	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	
Post Mortem Post 2000	**4** organs have been retained since the year 2000 (relating to 3 deceased patients) and subsequently disposed of by burial.
Other	(20 miscarriages)- **11** fetuses and **9** products of conception were disposed of between and 2001 and 2005.The figures are not as clear from 2005 and it is reported that an average of **8-10** fetus are disposed of per year since 2005.

Policy and practice

- The hospital has considered its policies in the light of the national guidelines for the storage, removal, retention and disposal of organs. Revised documents have been accepted at Board level and ratified accordingly. The hospital has fully implemented these revised policies and they are of an *excellent high standard.*
- There is an effective manual logging system in place.
- The hospital does not monitor effectiveness and retention levels of information disseminated to bereaved relatives at the time of post-mortem examination but is confident that if the level of information provided at this time was poor, and led to a complaint by either the family, or a member of staff, it would be investigated as an adverse incident as outlined below:

  'All incidents… are investigated in order to learn from mistakes and improve the quality of service delivered at KGH. In 2006, and as part of ongoing effort to improve patient safety a 'Revised Incident Reporting/Accident Reporting System' (consisting of documents along with Incident/Near Miss Hazard) was devised by Kerry General Hospital and approved by the Executive Management Board. The new Incident Reporting System was rolled out across the hospital in 2006. Investigation and analysis is carried out by the Root Cause Analysis process. Information regarding recommendations and learning is disseminated, policies etc. reviewed and amended where required'.[13]
- The incident reporting procedure referred to above has an inbuilt mechanism to enable feedback into the organisation to enable a process of continual improvement in services. Where necessary, incidents may also be investigated through the complaints process.

Recording and tracking

- The hardback records are quite basic.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families -Consent

- The doctor is personally responsible for obtaining written informed consent to post-mortem examination and no other healthcare professionals are involved in the process.
- Doctors are aware that there are policies for obtaining consent to post-mortem examination and these policies are made available to all staff. *Good practice.*
- The doctor responsible for obtaining consent is not usually a pathologist and therefore not qualified to perform a post-mortem examination and the majority of doctors are unlikely to have seen a post-mortem examination being performed.
- The process for obtaining consent to post-mortem examination is outlined in the Kerry General Hospital Policy for Obtaining Consent, which also includes relevant standard operating procedures and associated consent forms. *Good practice.*
- Although the hospital has trained specific staff to obtain consent and provide full information about post-mortem examination practice, one or two areas for improvement were identified by the hospital (see actions).

Storage and disposal of organs

- Since 1995, fetus' and stillborn babies have been buried in the Plot of the Angels, Rath Cemetery, Tralee.
- Organs have also been disposed of by burial.

Bereavement support services

- There is no dedicated bereavement officer.
- The pastoral care centre and nursing and medical staff deliver bereavement services. The Executive Management Board of the hospital is responsible for quality assurance.

  The hospital has identified the employment of a dedicated bereavement officer as a priority with the HSE and it is included in the 2007 and 2008 Estimates process.[13]
- While some of the facilities are available within the hospital the space is completely unsuitable and inadequate for breaking bad news to families.
- There is no specific viewing area although the chapel of rest is utilised for this purpose at KGH mortuary.

Information leaflets

- In the absence of a universal bereavement pack, various individual documentations/aids are provided, e.g. miscarriage booklet, bereaved children information, as well as local and national bereavement support group contacts. *Good practice.*
- There is also a very comprehensive booklet produced by Kerry General Hospital 'Information for the next-of-kin/relatives on a post-mortem examination'. *Good practice.*

Areas for improved focus/action

- Review logs and recording mechanism; consider the introduction of an electronic system as in the laboratory.
- There is no office furnishing/equipment for the technician; this should be reviewed.
- Currently there is no specific training for staff to enable information relating to retention of organs to be given to bereaved people following an unexpected death or in circumstances where a post-mortem examination is to be conducted under the jurisdiction of the coroner. *This is a national problem.*
- As KGH itself has stated: *'Particularly during times of change over of NCHD staff communication and overseeing of the policy can be difficult to achieve. It is anticipated that a dedicated Bereavement Officer could take on the communication of information to specific groups of staff at induction' ….. Improved communication and training regarding this policy is required, particularly at NCHD level. A dedicated Bereavement Officer has been identified as a priority for the hospital'.*[13] This should be actioned as soon as resources permit as a high priority.
- There is an urgent need to update the mortuary/post-mortem examination facilities at Kerry General hospital (see below).

- Post-mortem examination facilities are poor. Review refrigeration facility as can cause difficulties at time of post-mortem examination.
- Technicians facilities are stark and in need of refurbishment. There is no office equipment, no designated clean/dirty areas nor male/female changing areas. Shower facilities are poor for technician and pathologist.
- The post-mortem examination suite is badly in need of refurbishment.
- The floors are hard to clean, making it difficult to maintain levels of infection control. There is poor drainage and ventilation and much of the equipment is in need of upgrading.
- There is no indication when a post-mortem examination is in progress. Lone working is an issue; the technician can often be alone with no mechanism of checks or communication.
- There is no observation area, not all cabinets/shelving are stainless steel and all are in need of updating. There is also need for an internal recording system for the pathologist to dictate to.
- There is no proper storage facility for hazardous chemicals.
- Security is poor and there are no access control systems.

Letterkenny General Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	1 (in Dublin)	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	
Post Mortem Post 2000	• A total of **17** organs had been disposed of since the year 2000. • The audit team were informed that the method of disposal currently in use is incineration. This is wholly unacceptable. • No information was provided with regard to the disposal of fetus'.

Policy and practice

- The hospital has not currently considered its policies in respect of national guidelines for the storage, removal retention and disposal of organs, and has no current plans to do so.
- There is reasonable documentation (excluding policies) on the maternity wards but no continuity of documentation within the hospital.
- There is a flow chart for bodies being moved in and out of the hospital and checklist of action to be taken at the time a baby dies or a miscarriage occurs, together with a checklist to guide staff in the event of an identifiable fetus being delivered. However again there are no substantive policies or standard operating procedures. This minimal amount of policy /procedure and associated documentation.

Record Management and Tracking

- Post-mortem examination reports are appropriate as is the laboratory documentation. The mortuary records are hard copy.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families- Consent

- The pathologist will meet with families to answer questions related to post-mortem examination on request. *Excellent practice.*
- No training has been provided to staff to enable them to obtain consent to post-mortem examination and provide full information about post-mortem examination practice.
- A doctor always takes consent for a hospital post-mortem examination, and the doctor is always responsible for ensuring that appropriate and informed consent is obtained. No other healthcare professionals are involved.
- It would appear that there are 2 consent forms in operation at Letterkenny and as neither was version controlled it was difficult to see if one superseded the other or not.

Storage and disposal of organs

- There were no organs currently stored.
- The disposal of organs is reported to be at the choice of the next of kin to be returned to them for burial or to be interred in a designated hospital plot in the local cemetery.

Bereavement support services

- There is no bereavement service.
- However, the pathologist will meet with families to answer questions related to post-mortem examination on request. *Excellent practice.*
- There is a counselling request form. However at the time of the visit this service was unavailable.
- A hospital register is available within the hospital where details of babies who have died can be recorded, irrespective of gestational age. This register records patient's name and address; patient's age; gestation of baby; babies name; place of delivery (home or hospital); burial; (private or hospital) consultant; photo; and record of whether this was a confidential pregnancy. This is especially provided for those who have babies less than 24 weeks gestation and cannot register their birth formally. *Good practice.*
- There is no dedicated relatives' room. A ward/sister's office or other office is used for this purpose. There is a viewing area with removable religious symbols, accessible to wheelchair users.
- The hospital provide every woman who has suffered the death of their baby with a candle which can be kept as a memento or which the mother can light on the anniversary of their miscarriage as a memorial to the child who did not survive. *Good practice.*
- Following a pregnancy loss the mother will be contacted by a hospital social worker and a pregnancy loss clinic is held every 3-4 weeks. *Good practice.*
- Patients who have experienced a miscarriage are invited to the clinic by letter as a matter of routine and there is a remembrance service. *Good practice.*

Information leaflets

- Information was offered to patients suffering miscarriage.
- There is a hospital information leaflet for bereaved people where a post-mortem examination has been requested or required, but the leaflet does not explain that organs may be removed at post-mortem examination, or subsequently retained.

Areas for improved focus/action

- There is an urgent need for the hospital to review and implement policies and standard operating procedures.
- Following the urgent review and change of policy and standard operating procedure relating to disposal already referred to, the revised methods of disposal need to be clearly explained to families on each occasion.
- The hospital should also review and produce an appropriate consent form.
- Appropriate monitoring systems should be introduced.
- Immediate action should be taken with regard to the production of appropriate logs; proper recording mechanisms should be put in place, ideally in electronic format.
- Training in seeking consent should be provided.
- Services should not be offered that cannot be provided (such as a counselling service) and all information should be withdrawn until the service can be resumed.
- The mortuary facilities are in need of some modernisation.

Note: (There were a number of specific issues highlighted by the Audit team to the HSE that required immediate action ahead of the publication of the report. One of the issues highlighted was the practice of the disposal of organs by incineration at Letterkenny General Hospital. The following has been noted by the audit team in relation to the specific issues raised.)

- It was confirmed in writing, on 12th January 2009, by Letterkenny General Hospital to the HSE that the practice of disposal of organs by incineration ceased at the hospital in 2002.
- The letter of 12th January 2009 also confirms that in coroner and hospital post mortem cases the next of kin are offered organs retained at post mortem examination for internment once released. If they do not exercise this option the organs are interred at the Holy Angels plot in the local cemetery.

Louth County Hospital, Dundalk (LCH)

All post-mortems from Our Lady of Lourdes, Drogheda (OLOL) are carried out at Louth County Hospital (LCH) together with post mortems originating in LCH. All organs and tissue samples removed at post-mortem examination are sent to OLOL. No audit tool was completed by LCH as they send all their specimens to OLOL. **There are comprehensive plans in place for a new mortuary at OLOL starting January 09' expected completion June 09' when the current arrangement will cease and post-mortem examinations will no longer be carried out at LCH. It is understood that this project has been delayed.**

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Comments: **There was a statement that no organs are removed and retained here; however it came to light that at least one organ was retained and held here for several weeks. Normally if organs are removed they are taken to OLOL. It is understood that this project has been delayed.** It should be noted that with regard to the removal of organs and tissue the practice of the 2 pathologists is different. One pathologist removes specimens and transports them to OLOL from LCH. The other pathologist puts all tissue in cassettes at the time of the post-mortem examination and returns all residual tissue to the body. It would only be in the case where an organ is retained that an organ would be transported for this latter pathologist.			

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	0
Other	0

Policy and practice

- There are notes described as procedures.
- There are no appropriate policies and standard operating procedures in place.
- There are no policies and standard operating procedures shared between LCH and OLOL; they should jointly review and implement joint policies and procedures.
- What documentation is in place is very poor.

Record Management and Tracking

- Barely adequate hardback records maintained.
- Specimens have post-mortem examination number on but no identity or record on premises of what was taken.
- There is no organ register.
- The audit team was informed that a clinical incident reporting system is in place within the hospital; however the staff in the mortuary were not familiar with it. Even if staff from another hospital were using the facilities, they should still be conversant with the systems in place at this hospital.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families - Consent

- Consent sought only by treating clinicians on the ward or by Non Consultant Hospital Doctors.
- No training was in place.
- No consent form was provided.

Storage and disposal of organs

- There is no suitable organ storage on site.

Bereavement support services

- No evidence was provided.

Information leaflets

- No evidence provided.

Areas for improved focus/action

- **There are comprehensive plans in place for a new mortuary at OLOL starting January 09' expected completion June 09' when the current arrangement will cease and post-mortem examinations will no longer be carried out at LCH. This will in turn resolve all the issues raised below. It is understood that this project has been delayed.**
- Review and implement appropriate data recording systems to include registers, logs and tracking.
- There is an urgent need for proper policies and procedures to be in place at LCH that are adhered to by the staff at LCH and the staff from OLOL when working on the premises. It is essential that there are defined roles and responsibility and clear line of accountability; there should also be service level agreements between the hospitals that the staff understand and adhere to.
- Review and implement monitoring structures.
- There is a need for effective joint consultation and working with regard to all the above.
- The mortuary is running at serious organisational risk and a risk assessment should be undertaken with immediate effect. The risk assessment should include Health and Safety observance, Control of Substances Hazardous to Health (COSHH), appropriate use of Personal Protective Equipment (PPE) and dignity and respect.
- Immediate review of the transportation of specimens as the current arrangements are not appropriate.
- Implementation of bereavement services and an Anatomical Pathology Technician to manage the mortuary.
- Information and bereavement pack for the deceased's relatives.
- The mortuary is in need major modernisation.
- **The new mortuary at OLOL will be a modern facility, the pathologists are based at OLOL and the majority of the work is sourced at OLOL therefore work from LCH will move to OLOL and alleviate the above failings. Centralisation and modernisation of services is essential.**

Our Lady of Lourdes Hospital (OLOL) Drogheda

All deceased patients for whom a post-mortem examination is required are transferred to Louth County Hospital (LCH) for it to be performed.
All organs and tissue samples removed at post-mortem examination are transferred back to Our Lady of Lourdes Hospital (OLOL), Drogheda for examination from LCH.
There are comprehensive plans in place for a new mortuary at OLOL starting January 09' expected completion June 09' when the current arrangement will cease and post-mortem examinations will no longer be carried out at LCH. It is understood that this project has been delayed.

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**1**	0
Children	**1**	**1**	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	**5** organs disposed of following a CPM.

Policy and practice

- The policies provided to the audit team were quite limited, although reasonable in themselves. However, none of the pathology/mortuary staff were aware of them. The audit team spent two days looking for them and then they were appended to the audit tool that was not given to the team until they left.
- The hospital state the policies have not yet been ratified because the hospital has partially implemented revised policies. However, as a pilot site for the Newgrange process they initiated a process of care, which ultimately led to the Hospice Friendly Hospital programme.
- On a second visit to the hospital it was apparent much work was in progress in relation to standard operating procedures leading up to the build of the mortuary facilities.

Record Management and Tracking

- The documentation/logging of organs and tracking of the disposal of organs within the hospital needs attention.
- The hospital does not monitor the effectiveness and retention levels of information disseminated to bereaved people at the time of post-mortem examination although any complaint received concerning the quality or delivery of information provided to bereaved people would be investigated as an adverse incident utilising the risk management process.
- Complaints from families are co-coordinated through the Patient Liaison Department and a process of multidisciplinary review of all complaints is used to improve policy development.
- The hospital does monitor instances in which the process surrounding organ retention, consent and the support provided to bereaved relatives was poor, utilising the adverse incident reporting system, and has taken steps to quality assure the service provision to a consistent standard.
- Any occasion when the delivery of information to bereaved people was considered poor, or where the body of a deceased person may have been inappropriately handled, would lead to a full adverse incident investigation as part of the risk management process. In addition each pathologist takes responsibility to

ensure that organs s/he retains are dealt with appropriately and any complaints would be channelled to the relevant consultant pathologist.

- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families - Consent

- A doctor is always involved in taking consent and is ultimately responsible for finally obtaining written consent to post-mortem examination. A nurse, midwife or chaplain always supports him in a multidisciplinary approach.
  However, the 'consent form' is not version controlled and provides very little information regarding the purposes of the post-mortem examination or reasons for the need to retain an organ. It simply consists of the following:

    - 'I consent to a post-mortem examination being carried out on the body *of ..... and I am not aware that he/she had expressed objection or that another relative objects.'* and

    - 'I understand that this examination is carried out to verify the cause of *death and to study the effects of treatment, which may involve the retention of tissue for laboratory study*.

    - Signed, Relationship with the deceased, Witnessed by and date.[14]

  This is a very poor example of consent documentation and needs to be withdrawn and replaced immediately.

- At present the staff taking consent do not all receive individual training; although the hospital say they are developing training in this area, and already consider that action is taken to ensure consent is properly obtained.
- The NCHD/consultant supported by the nursing team meet with the family and outline the process involved regarding a post-mortem examination before written consent is obtained.

    - *'Very rare hospital post mortems at the moment (and) junior medical staff turnover every 6 months. Pathologists consider that it is the responsibility of the Clinical Consultant to ensure the clinical team take consent correctly. We are available for advice....'*[14]

- The doctor responsible for obtaining consent may not be a pathologist and is not therefore qualified to conduct the procedure for which consent is being taken. If the pathologist is concerned that consent may not have been properly obtained s/he will speak to the clinician involved on the telephone.
- The hospital say a process is in place to ensure information relating to retention of organs is available to families in respect of unexpected death and/or where a post mortem is to be conducted under the jurisdiction of the coroner, although there is no written protocol for this available.

Storage and disposal of organs

- There are some electronic logs relating to retained organs post 2000 and a hardback book, plus the pathologists notes, an organ register should be in place.
- It should be noted that with regard to the removal of organs and tissue, the practice of the 2 pathologists is different. One pathologist removes specimens and transports them to OLOL from LCH. In contrast, the other pathologist puts all tissue in cassettes at the time of the post- mortem examination and returns all residual tissue to the body. It would only be in the case where an organ is retained that an organ would be transported for this latter pathologist.

- The hospital does not have any fetal material or stillborn babies post-dating the year 2000 currently retained. Neither have they disposed of any identifiable or unidentifiable material since the year 2000 except by burial:

    - *'On receipt of babies from maternity parents may wish to bury the baby themselves, if not the deceased is taken from the Mortuary to the Holy Angels plot by the Maternity Porter and given to the grave attendant for burial'* .[14]

- Transportation arrangements for specimens from LCH to OLOL are unacceptable as there are no standard operating procedures in place. Evidence suggested that on some occasions an undertaker would transfer an organ for LCH to OLOL. Use of Bio-Hazard bags and appropriate transportation coupled with an inter hospital standard operating procedure should be introduced immediately.

Bereavement support services

- The Regional Development Coordinator, mortuary technical officer and chaplain are responsible for the management of bereavement services under the auspices of medical/nursing and operational management directorates.
- Despite requests to meet social workers this did not happen; it appeared that social work was not seen as providing care or support following death. They may be involved but this was not how it was presented to us.
- Chaplains appear to provide support, which is available particularly in maternity.
- The Audit team met the Hospice Friendly Hospitals coordinator whose role was not clear at time of our visit. He was newly appointed to post.
- One dedicated relatives' room was developed as part of the Newgrange process. This is a nursing office that can be converted to a quiet room as required. Otherwise ward offices or vacant areas are used.
- There is a viewing room containing removable religious symbols and sacred texts can be provided on request. The area is wheelchair accessible. The viewing room is adequate but in need of modernisation.
- The environment outside the viewing room is not suitable for bereaved families. There was a strong feeling amongst staff that they felt that it was a retrograde step that the oratory adjacent to the maternity ward had been lost.
- The hospital provides a bereavement information pack including an expression of condolence; contact details for hospital, local and national support service, ward and switchboard telephone numbers; and information about death certificates and registration.

Information leaflets

- There is a Drogheda information booklet about post-mortem examinations that does speak of the organ retention of organs at post-mortem examination.
- Hospice Friendly Hospital leaflets were provided.

Areas for improved focus/action

- There are comprehensive plans in place for a new mortuary at OLOL starting January 09' expected completion June 09' when the current arrangement will cease and post-mortem examinations will no longer be carried out at LCH. **If the planned new facility and governance of the new facility proceeds then this will resolve many of the concerns below.**
- There are no clearly defined roles and responsibilities between the 2 hospitals and little communication. There is an urgent need for joint working in relation to the use of the facilities and the joint development of policies to support this.
- A number of staff are rightly uncomfortable that there is no oratory for parents and their baby who has died, especially at a hospital where there is a very large birth rate. *On the audit teams second visit this was still the case however there are plans for a second viewing room in the new mortuary and also potential in future building projects for this to be addressed.*
- There is general need to review and revise documentation and a need for training and implementation of standards.

- The management of the hospital needs to take responsibility for joint working practices with LCH.
- The policies and standards of practice observed in this hospital relating to the logging and tracking of specimens are poor and there is no evidence of joint working between the 2 hospitals.
- Although the pathologist based at OLOL performs post-mortem examinations at LCH, there are no policies in place at LCH with regard to the proper use of post-mortem examination facilities; body-preparation; transport; etc. nor are there any standard operating procedures.
- Although the tracking and recording of organs and tissue was adequate, as a matter of urgency there should be a review of the arrangements for the transportation of tissues and organs removed at LCH and sent to OLOL, to include their packaging.
- The post-mortem examination room at OLOL has closed and is not suitable for use. There is no refrigeration for babies on the wards where the very warm environment is not compatible with preserving a body. As a result, the time a family can spend with their baby is limited - new facilities are required to remedy this.
- Support services appeared extremely poor. There is no formal support structure for staff and documentation is limited and poor. *There was evidence on the second visit that some of these issues were being addressed.*

Mater Misericordiae University Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**7**	0	Plus one organ sent to another hospital for examination.
Children	0	0	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	
Post Mortem Post 2000	**30** returned to the family/Next of Kin (N.O.K) **21** buried in MUH plot **1** organ cremated at requested of N.O.K

Policy and practice

- Documentation, policies and standard operating procedures *are excellent*, comprehensive and all versions controlled and ratified.
- In addition there was a very comprehensive mortuary procedure file, which can only be regarded as *excellent practice*.
- There is evidence within the organisation that policies are embedded.

Record Management and Tracking

- The social work department currently monitors systems and process for the effectiveness and delivery of information at time of post-mortem examination. There is also monitoring through the hospital incident reporting system. *Excellent practice*.
- Organs logs are also very comprehensive and in an electronic format and well kept within the mortuary. *Excellent practice.*
- Lessons learned are fed back through the hospital's executive committees (Medical, Nursing and PAM - professions allied to medicine) and through the hospital's Risk Management Committee and patient care committee. *Excellent practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families – Consent

- The social work department delivers an excellent service with regard to the follow-up support relating to the retention of organs at post-mortem examination.
- The hospital report that a doctor, nurse and social worker are usually involved in the process of seeking consent, and that those people seeking consent have received training to do so.
- However the hospital does recognise the need for continuous training because of the rotational change over of Non Consultant Hospital Doctors (NCHD); this is especially crucial in the Emergency Department.
- The consent form is appropriate.
  The above is good practice.

Storage and disposal of organs

- All storage appropriate.
  It is noted in hospital documentation:

  > *'within three months of the post mortem, retained organs will be released by the hospital for cremation at Glasnevin Crematorium and the ashes returned to the hospital" and later''ashes from Glasnevin Crematorium will returned to the family in a suitable manner'.*

  There is debate internationally about this but there is no documentary evidence to suggest that there are any residual ashes from a cremated organ, only from the casket. (See Section B).

Bereavement support services

- Support is offered from social workers to bereaved families at the time of death on wards and in the emergency department.
- There is an integrated service supported by experienced mortuary staff. *Excellent service.*
- A social worker is designated to deal with any organ retention issues and to ensure no issues arise for families. *Good practice.*
- The bereavement support service is focused on documentation regarding post-mortem examination issues. *Good practice* .
- There is a service of removal and burial for retained organs during post-mortem examination at the Mater Misericordiae. *Very good practice.*
- The head medical social worker sees the bereavement service as appropriate to the social work department but is unable to expand the service, as she would like.
- The chaplaincy is involved in a sacramental role. *Good practice.*

There are 2 reasonable viewing areas for families to view the deceased. One contains no religious symbols. The viewing area also has wheelchair access.

Information leaflets

- There are a variety of leaflets and letters available for the deceased's relatives. These are of a high standard.

Areas for improved focus/action

- There are extensive and excellent plans in place to extend and update the mortuary. A significant amount of work has gone into a contingency plan for the 6 month period that the mortuary has to move to the Mater Private. It is important that there should be no interruption to service whilst the build is underway. *Evidence of excellent planning.*
- Review cremation and the return of ashes.
- Excellent policies yet many of them were past their review date. The hospital did state that all documentation is currently under review.
- It is *excellent practice* that staff have been trained about policy and standard operating procedures and that there is a training record of this; however it is essential that the policies are up to date - hence the need for the review already referred to.

Mayo General Hospital, Castlebar

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	0
Post Mortem Post 2000	0

Policy and practice

- There were a variety of policies and standard operating procedures in place at Mayo General Hospital. However a number of these policies and procedures were not version controlled and in some cases it was unclear precisely to what the document applied or how it was anticipated it would be used.
- Notwithstanding comments about some of the documentation provided as part of the audit there were a number of documents with *good version controls,* although these did not all indicate when they had been ratified, or by whom.

Record Management and Tracking

- Mortuary recording is in hardback format.
- The hospital does not monitor effectiveness and retention levels of information disseminated to the bereaved at the time of post-mortem examination. However, if a complaint was received about the quality of information provided to relatives about the post-mortem examination this would be investigated as an adverse incident and/or as part of the complaints management system. Any learning from the investigation of incidents is fed back into the organisation via the incident reporting and complaints management processes, which are integral to the hospital's clinical governance system.
- Instances in which the processes surrounding the management, storage, use, removal, retention and disposal of organs, consent to post-mortem examination, and/or the support of bereaved relatives were poor, would be investigated as adverse incidents if they were reported. The consultant histo-pathologist is responsible for the quality assurance of these areas and for maintaining a consistent standard.
- Circumstances where it is reported that the information regarding the retention/disposal of an organ has been poorly delivered, or where the body of a deceased person may have been inappropriately handled, are investigated as an adverse incident and also through the complaints management process.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families' -Consent

- The pathologists at the hospital are very willing to speak with any next-of-kin who wanted information regarding the post-mortem examination. *Excellent practice.*
- The person taking consent is always a doctor and s/he is ultimately responsible for finally obtaining written informed consent to post -mortem examination.
- No other health professionals are involved in the consent process.
- The doctor taking consent has received instruction about the process and as a pathologist is qualified to perform the procedure for which consent is being taken.

- The process for obtaining consent is described in the *Post-Mortem and Deceased Patient Policies*, which were contained in the portfolio of supporting evidence provided by the hospital.
- The neonatal/paediatric consent form and a general consent form used in the hospital are both appropriate.

Storage and disposal of organs

- Disposal is covered in hospital documentation; the next of kin are given a choice between hospital disposal, which is by burial or cremation, or the return of the organs for them to organise respectful disposal.
- However the hospital informed the audit team that they do not retain organs.

Bereavement support services

- There is no dedicated bereavement officer, but the medical social work department is involved with patients.
- The head medical social worker provides supervision for social workers working in the hospice care team.
- The audit team was not accorded an interview with the chaplains but the social workers say they link in with them. Support services for families are adequate.
- There is a general relatives' room and the ward sister's office is used to break bad news to families.
- The viewing facilities are of a reasonable standard. The viewing area does not contain religious symbols but these, together with sacred texts, can be provided on request. The area is wheelchair accessible.

Information leaflets

- There is a very helpful information leaflet indicating what should happen regarding the removal, storage, retention and subsequent disposal of organs following a post-mortem examination ordered by the coroner. This is very clear about the need to ascertain the views of the bereaved relatives concerning disposal of these organs which is especially important as this is one of a very few choices available to relatives when a coroner's post-mortem examination is required by law. *Good practice.*
- There is what looks like a post-mortem examination information form but again it has no heading or version controls in place.
- The social work department has developed an excellent booklet and refers to what is described as an excellent bereavement service in the town. The hospital also provides its own booklet entitled 'We Remember - a handbook for those affected by grief". This mentions post-mortem examination but not the possibility of organ retention, and therefore the booklet would benefit from revision and updating in order to ensure that information provided to bereaved relatives is as accurate as possible.
- The review also identified a number of leaflets which had been printed directly from the internet site of the Miscarriage Association.
- In the case of a coroner's post-mortem examination there is a booklet available for relatives; staff are aware that this booklet needs to be given to relatives in the event that the coroner orders a post-mortem examination.

Areas for improved focus/action

- The hospital should review its policies and standard operating procedures.
- The organisation would benefit from a broader application of version control procedures to all policies.
- There is a need for continuing professional education for anatomical pathology technicians especially relating to dignity and respect for the deceased patient. This should be commenced with immediate effect.
- The hospital would benefit from the electronic recording of mortuary logs.

Mercy University Hospital, Cork

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Comments: The hospital indicated that no coroner's post-mortem examinations were undertaken and therefore no specific training was provided to staff regarding retention of organs following unexpected death and a post-mortem examination ordered by the coroner.			

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	0
Post Mortem Post 2000	**2** organs were removed at Mercy Hospital and retained at CUH. In relation to disposal CUH state organs returned to Mercy. Mercy Hospital indicates that the organs were not returned to them.

After the 1st visit of the audit team, they were informed by the Senior Management that Mercy Hospital has ceased to perform post-mortem examinations at the hospital. If a post-mortem examination is necessary then it will be undertaken at Cork University Hospital.

Policy and practice

- The hospital state they have considered their policies in respect of current national guidelines for the storage, removal, retention and disposal of organs, but at the time of the audit those policies were not made available to the audit team and they were told they had not been formally reviewed and revised. They anticipated that this formal review of policies would be undertaken within 6 months and that any revised policies arising from that review would be submitted for ratification within 12 months. (1st visit).
- The hospital state that the best description of their current position concerning implementation of revised policies was 'not being implemented'; explaining however that revised policies were not necessary because of the activity of the hospital and the policy of removing but not retaining organs from hospital post-mortem examinations.

Record Management and Tracking

- As part of the audit process there is a requirement to observe logs with regard to post-mortem examinations undertaken and organs retained, evidencing recording and the tracking relating to these. No such documents were available to the audit team upon the first visit to the hospital and there was a declaration that no organs had been retained at Mercy Hospital post 2000.
- Upon cross checking with another hospital it became apparent to the audit team that there was information about two cases of 'organs' being sent to a referring hospital for further investigation.
- The hospital confirmed after the 1st visit that:
    - The original Disclaimer was incorrect.
    - It has not been the practice of the hospital to retain organs for any other purpose than the completion of a post-mortem examination investigation, organs have been removed at Mercy and sent to CUH for further investigation
    - **The audit team was satisfied with correspondence and on a second visit that consent for the two cases was recorded appropriately in the patient record.**

- The hospital indicated that there are no systems in place to monitor the effectiveness and retention levels of information disseminated to bereaved people at the time of post-mortem examination but if it did become apparent that information had been poorly delivered it would be investigated as an adverse incident.
- There was an expectation that whom-ever the incident was reported to would follow it through and ensure it was appropriately reported. This report would be highlighted to the departmental manager who was tasked to investigate and take corrective action. The risk management department would audit the corrective action and be responsible for ensuring that any lessons learned from the incident were fed back into the organisation. This process was seen as integral to the hospital clinical governance system although the responsibility for clinical governance of support services was not centralised but was instead delegated to the individual service heads and consultants.

Communication with families –Consent

- The doctor was always involved with taking consent to post-mortem examination and was indeed ultimately responsible for finally obtaining written consent.
- The hospital did not indicate that any other professionals would be involved in this process.
- The process for obtaining consent was briefly described:
- *'Next of kin approached by doctors with reason for requesting hospital post-mortem'* .[15]
  The Doctors had received training in obtaining consent to post-mortem examination, although the hospital added 'as part of their medical training' so it is unclear whether this is specifically in relation to consent to post-mortem examination and the relevant information giving, or whether it relates to a more general training in obtaining consent which is then applied to taking consent to post-mortem examination.
- The consent form was appropriate.

Storage and disposal of organs

- No policies or evidence provided as the hospital informed the audit team that organs were not retained.

Bereavement support services

- Chaplaincy staff are responsible for the management and delivery of bereavement services.
- There are dedicated relatives' rooms close to the ward area. There is a viewing area containing *non-removable* religious symbols, which cannot be hidden. The area is accessible to wheelchair users.

Areas for improved focus/action

- The post-mortem examination facility is not fit for purpose. **Since the 1st audit visit the audit team were informed by the Senior Management team of the hospital that the facility at the Mercy hospital no longer performs post-mortem examinations.**
- The hospital should consider having a viewing area where religious symbols can be removed, considering the multi-cultural, multi-faith climate today.

Mid Western Regional Hospital, Dooradoyle

The MWRH receives bodies from the Mid Western Regional Maternity Hospital (MWRMHL); Ennis General Hospital (EGH); and the Nenagh General Hospital (NGH).
NB: EGH was not visited as the performance of post-mortem examinations ceased prior to 2000.
However NGH did not cease to perform post-mortem examinations until 2003. Therefore the audit team visited the NGH. The former post-mortem examination suite had not been in use for a very long time and some parts were left redundant with other parts used for storage. There were no organs stored there.

Validation Status – *Validated (√)*
Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**1**	**(2 for education and research in London)+ 11 organs at other hospitals for examination**
Children	0	0	0
Fetuses	0	0	0
Comments: An observation that was quite disconcerting to the audit team was that organs have been sent to Beaumont Hospital for further examination in 2001, 2003, 2004 and 2006; the hospital note on their organ log is *'still awaiting information from Beaumont'*.[16] **There should be a responsibility after several weeks to check the status of the organs by the referring hospital**. There is a failure at this hospital, both in the tracking and audit of cases, which in turn implies a failure to treat the next-of-kin properly.			

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	**3**

Policy and practice

- On the first visit by the audit team no policies or standard operating procedures were provided. However these were provided on the second visit. When polices and procedures were provided, they were of a *high quality and were version controlled*. However, there are a number of documents that are past their review date and are in need of revision. Although there is good documentation there was little evidence of it being embedded within the system.

Record Management and Tracking

- Tracking and recording is of a reasonable standard. Except regarding the organs sent to other organisations for examination.
- On carrying out an audit trail check on cases, the cases checked were traceable.
- No evidence was presented by the hospital to indicate that they monitor the effectiveness and retention levels of the information given to the bereaved at time of post-mortem examination, nor did they have any record of any adverse incident or complaints reported with regard to the post-mortem examination or bereaved relatives.
- Incident reporting forms to be filled out by patients or members of staff are available. There are several ways of reporting incidents verbally, and an incident form will be completed, as a complaint through 'your service - your say', or as a formal written complaint. However it is not evident what understanding

there is amongst staff and others about these procedures and forms, or indeed if members of the public would know to report incidents at all.

- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- It is always a doctor who seeks consent for a post-mortem examination, and the hospital reports that the doctor is trained in seeking consent, but does not elaborate on how and when this training takes place.
- The clinicians responsible for the care of the deceased are responsible for obtaining consent from families in the case of diagnostic post-mortem examinations. They are responsible for training their respective medical team on obtaining consent.
- The hospital also stated:

  'There is currently a document with the HSE West Mid-Western Area solicitor for approval on 'Guidelines on obtaining Patient Consent' which includes guidelines on obtaining consent for post-mortems. Training will be rolled out as part of the implementation process. Copies will also be available on wards.'[17]
- With regard to other training the hospital has an ongoing training program with annual breaking bad news sessions, communication skills and cultural awareness. *Good practice.*
- All staff can access this although there was no evidence of any requirement to attend these courses or training records presented to the audit team nor does this training cover seeking consent.
- The consent form was appropriate.

Storage and disposal of organs

- The storage of organs was appropriate.
- The audit team was informed that if the family requested the burial of an organ or the return of an organ those wishes would be followed. However if no such wishes were made the organ would be disposed of as surgical waste. ***Incineration is wholly unacceptable by today's standards.***
- The audit team made further inquiries with regard to the practice of incineration to which the response was *'The MWRH Mortuary does not incinerate organs as policy-small pieces of tissue (appx.1cm2) post histology 'cut-up' process, are sent for incineration via MWRH Waste Removal contractors, as per policy. In Non-Coroners cases (Hospital PMs) where consent is obtained (including options of disposal) for tissue sampling following Histological diagnosis, this tissue is then disposed of as per policy. On rare occasions larger pieces of tissue or organs are sent for cremation/incineration at the specific request of the next-of-kin/families.*

  In 'Coroner' cases, should any whole organs be kept, the coroners are informed. To the best of our knowledge they in turn inform the families as to what organs have been retained for specialist investigations, and why. However, this point may need further clarification via contact with the Coroners office/Ministry of Justice.

  When an organs is returned to the mortuary after specialist testing the MWRH Mortuary staff contact the relevant undertakers who in turn contact the families concerned, and they are then given the choice of the method of disposal of the organs. If organs are to be sent for cremation/incineration, this is as per histological specimens. Methods of organ/organs disposal are not routinely discussed with the family/next of kin.'[17]

  Firstly this response was written in particularly obtuse language, which leads to confusion. Families/next of kin should be routinely given choices and information with regard to the methods of disposal and secondly Cremation and Incineration are not the same and should not be linked as such. It is totally misleading to inform a family/next of kin that an organ is to be Cremated and it actually be incinerated.

Bereavement support services

- The Mid-Western Regional Hospitals do not have a bereavement officer and there is no dedicated directorate with responsibility for management of bereavement services.
- The pastoral care team/chaplaincy may refer the bereaved to bereavement counsellors if required in a private capacity.

- There are no bereavement policies.
- There are very few bereavement facilities, although the viewing facilities are appropriate.
- There is very little bereavement literature.
- Annual training is offered to staff on breaking bad news, communication skills, and cultural awareness.

Information leaflets

- There is a post-mortem examination booklet provided for obtaining consent for diagnostic post-mortem examinations.

Areas for improved focus/action

- Review and improve tracking of organs and create a standard operating procedure for the referral of brains to another hospital with immediate effect.
- Disposal of organs by incineration as clinical waste is unacceptable practice and should be ceased with immediate effect. There has clearly been no observance of the ERHA 2002 guidance.[9]
- There is a need to ensure that the very good policies are embedded organisationally.
- It is recognised that in the case of coroner's post-mortem examinations there are areas where the bereaved may not receive the necessary answers. The process of and responsibility for communicating with the bereaved involving both the coroner and the clinician needs to be more structured. There is no clarity about the care route with regard to a post-mortem examination carried out on behalf of the coroner nor if the clinician can speak to the relatives.
- The mortuary would benefit from all information being on an electronic system not just on part of it.
- Bereavement support is inadequate for a regional hospital and should be reviewed; a closer liaison with the maternity hospital could aid this.

Note: (There were a number of specific issues highlighted by the audit team to the HSE that required immediate action ahead of the publication of the report. One of the issues highlighted was the practice of the disposal of organs by incineration at MWRH General Hospital. The audit team sought satisfactory clarification in relation to this important issue).

- A comprehensive document of information was provided to the audit team by the hospital; this document did state that disposal can still be in line with hospital policy (if the family do not choose burial or cremation). Other documentation previously provided to the audit team stated that 'organs are sent for cremation/incineration - this is as per histological specimens'.
- Further clarification was sought. On the 10/07/2009 the Hospital Network Manager apologised for confusion caused by the use of the term "incineration/cremation" in documentation provided to the audit team and confirmed that practice at the hospital was that "the disposal of whole organs - on the very rare occasion when this does occur - is burial or cremation".
- In response to this clarification, the Hospital Network Manager has been asked to ensure that the wording in documentation relating to post-mortem examination is reviewed and, as necessary, strengthened, so as stated policy and procedures can be clearer in relation to the sensitive disposal of organs temporarily retained at post mortem examination.

Mid Western Regional Hospital, Nenagh.

The audit team carried out a visit to the hospital, as they were made aware that post-mortem examinations did not stop until 2003.

- The post-mortem examination room had clearly been out of use for many years.
- There was no evidence of any organs being retained on this site.

This issue was referenced earlier in the report “On one site visit, to a Hospital which had not provided a disclaimer and was therefore was routinely audited, it was indicated that a visit to a hospital that had provided a disclaimer was required. This hospital was visited and it was verified that the status of the disclaimer provided was correct. (see Nenagh Hospital)”.

Mid Western Regional Maternity Hospital, Limerick

All post-mortem examinations are performed at the Mid Western Regional Hospital Dooradoyle

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Comments: All questions answered '*Not applicable. All post-mortem examinations performed at the Mid Western Regional Hospital Dooradoyle Limerick.* and ***'No retention of fetus''-private or hospital burial as per hospital guidelines.***			

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	
Post Mortem Post 2000	
Other	All questions answered '*Not applicable. All post-mortem examinations performed at the Mid Western Regional Hospital Dooradoyle Limerick*

Policy and practice

- The documentation and policies at the maternity hospital are good including checklists, guidelines and standard operation procedures.
- All are version controlled and within the review period. The hospital has considered its policies against national guidelines.

Record Management and Tracking

- Monthly perinatal mortality meetings take place.
- The hospital has mapped the care route of a deceased patient and there is evidence of the outcome of this in the form of reports about delay in post-mortem examination reports. Concerns about poor communications raised by parents are investigated and explored by the multidisciplinary team. The head of each discipline is involved and the concerns are tracked and monitored. The lessons learned are disseminated through ward and audit meetings, memos and training days.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families –Consent

- There is a very skilled clinical midwife specialist in bereavement counselling. *Good practice.*
- A doctor always seeks consent; there is no indication of other professionals being involved. No information was provided with regard to training with regard to seeking consent.
- The consent form is appropriate.

Storage and disposal of organs

- *'Not applicable. All post-mortem examinations performed at the Mid Western Regional Hospital, Dooradoyle Limerick. 'No retention of fetus'-private or hospital burial as per hospital guidelines '.*[18]

Bereavement support services

- Miscarriage clinics.
- Follow-up clinics for bereaved relatives.
- Structured grief counselling.
- Dedicated counselling room plus two other dedicated rooms for families with deceased babies.
- There is a dedicated viewing room with removable symbols and is wheelchair accessible.

Information leaflets

- There is a good variety of bereavement literature available to parents. Good practice.

Areas for improved focus/action

- Training in seeking consent.
- A closer working relationship with Dooradoyle should be developed.

Midland Regional Hospital's, Tullamore, Portlaoise and Mullingar

Midland Regional Hospital Tullamore (MRHT) serves Midland Regional Hospital Portlaoise (MRHP) and the Midland Regional Hospital Mullingar (MRHM) with regard to organs and tissues removed at post-mortem examination and all policies and standard operating procedures are cross-organisational. Therefore all the information below relates to all 3 hospitals; any deviation from that position will be noted in this section under the hospital heading.

Validation Status – *Validated (√)*

Validation of currently retained organs – currently retained MRHT-MRHP-MRHM

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**1**	0
Children	0	0	0
Fetuses	0	0	0
Comments: It is noteworthy that the pathologists who perform post-mortem examinations at Mullingar and Portlaoise are based in Tullamore.			

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	**2** organs. No information was provided in relation to the disposal of fetus at Mullingar or Portlaoise at the time of audit. *Further information provided post the audit team visit indicated that after 2002 families are given a choice in terms of sensitive disposal of fetus'.

Policy and practice

- The hospital has considered its policies in respect of national guidelines for the storage, removal, retention and disposal of retained organs. *Good practice.*
- Policies have been formally reviewed and draft revised policies have been prepared and are of a good standard and are version controlled. *Good practice*.
- Policies appear to be embedded within the organisation at both Mullingar and Portlaoise Hospitals *Excellent practice.*
- It would appear that all brought-in-dead paperwork is managed by nursing administration. This appears to work reasonably well in Tullamore but not in Portlaoise. At Mullingar and Portlaoise there is a need to define and strengthen the roles and responsibilities of those involved and proper integrated working with regard to documentation should be introduced.

Record Management and Tracking

- All recording is currently on paper; it would greatly benefit from being computerised, particularly as electronic record keeping is especially beneficial where there is cross-site working.
- The tracking and sending of specimens is excellent all 3 hospitals, although the log system is somewhat primitive and needs to be updated to an electronic system as is used in the laboratory. However within the confines of current limitations the process is excellent, with specimens from each of the 3 hospitals clearly identified by a bar code system and individual colour coding.
- The specimens are transported via the appropriate laboratory transportation arrangements. Good practice.

- The hospital does not monitor the effectiveness and retention levels of information disseminated to bereaved people at the time of post-mortem examination.
- The hospital does monitor instances in which the processes surrounding the management of the storage, use, removal, retention and disposal of organs, consent and the support provided to bereaved people was poor through its adverse incident reporting systems. *Good practice.*
- There is clear understanding of incident reporting within the mortuary. *Good practice*.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- A doctor always takes consent for post-mortem examinations and is ultimately responsible for ensuring appropriate written informed consent is obtained. No other health professionals are involved in this process.
- The medical staff received training in obtaining consent and providing full information about post-mortem examination practice.
- The process for obtaining consent to post-mortem examination within the hospital was briefly described as:

  'There are no standing operating procedures for obtaining consent to post mortem examinations although a consent form and information leaflet are available '.[19]
- There is an appropriate consent form.
- There appeared to be no training provided for staff in relation to the retention of organs following an unexpected death and a post-mortem examination ordered by the coroner. This was deemed to relate only to patients brought into hospital dead (Brought in Dead - B.I.D.), which would be a matter for the general practitioner under present arrangements.

Storage and disposal of organs

- The storage was secure and appropriate.
- The disposal of organs is appropriate.

Bereavement support services

- There is no designated bereavement service.
- Nursing staff deal with bereaved relatives where the death takes place.
- A bereavement counsellor has been requested.
- A local counselling service can provide counselling to families where organs are retained.
- Chaplaincy is involved when needed.
- No dedicated relatives' room is available. There is a viewing area with removable religious symbols, which is accessible to wheelchair users.
- The post-mortem examination and viewing facilities are excellent (at Tullamore).

Information leaflets

- There is an information leaflet about post-mortem examination including the possible retention of organs. Good practice.
- No bereavement information pack is available apart from an information leaflet about hospital post-mortem examinations provided to relatives where appropriate.

Areas for improved focus/action

- Much work needs to be done to establish an effective bereavement service and support for staff dealing with bereaved families.
- There is a need to review the arrangements with nursing administration, especially in Portlaoise.
- There is a need for electronic logging systems in the mortuaries at all 3 hospitals.
- There is a need to review information for the bereaved and design a bereavement pack.
- The mortuary facilities at Portlaoise are in urgent need of expansion and modernisation.
- The mortuary facilities are in need of modernisation at Mullingar.

- There is a need for implementation housekeeping and a regularly staffed mortuary at Portlaoise and Mullingar.
- There is also a need for continuing education for Anatomical Pathology Technicians.

Naas General Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	
Post Mortem Post 2000	Since the year 2000 the hospital had disposed of **17** organs removed at CPM. In each case these organs had been removed from adult patients. These were disposed of by the AMNCH on behalf of Naas General Hospital (see below).

Policy and practice

- The hospital had a reasonable range of version controlled guidance documents. Obviously a great deal of effort has gone into creating the documents and also into ensuring that the initial consultation was good and the documents were approved and signed off, in the first instance by the mortuary committee.
- Unfortunately, at the time of the visit the documents had passed the date on which they should have been reviewed.
- All documentation with regard to the retention, and removal and disposal of organs was kept in an *excellent* fashion.
- Processes and standard operating procedures for obtaining consent to a post-mortem examination were not described to the audit team. However, appropriate protocols and standard operating procedures were included in the portfolio of evidence provided by the hospital during the audit.

Record Management and Tracking

- The hospital does not currently monitor the effectiveness and retention levels of the information disseminated to bereaved people at the time of post-mortem examination but, where information concerning post-mortem examination provided to bereaved families had been poorly delivered, this would be investigated as an adverse incident.
- The adverse incident investigation would be triggered following a complaint from relatives about the information provided to them concerning post-mortem examination. *Good practice*.
- Following the complaint staff involved in the incident would be interviewed, as would the relatives themselves, before a formal report was written. The investigation would be coordinated by the patient services manager and reported back to the Quality and Risk Management Committee after which policies would be amended as required. *Good practice.*
- Finally there would be a process of education to ensure the lessons learned were imbedded in the organisation. This may take the form of general education and training sessions, feedback sessions or one to one training sessions as appropriate. *Good practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- There is a designated individual who deal with all cases of retained organs. *Good practice*.
- The doctor and a nurse are always involved in taking consent to post-mortem examination and the doctor is always ultimately responsible for ensuring written informed consent to post-mortem examination is obtained.
- The pathologist may occasionally be involved in this process but no other health care professionals are ever involved.
- The hospital has trained specific staff to obtain consent and provide full information about post- mortem examination practice. They also have a process in place for information in relation to retention of organs in the event of unexpected death and/or a post-mortem examination conducted under the jurisdiction of the coroner.
- The staff obtaining consent have received training. It is not clear if the training is specific to taking consent to post-mortem examination or whether it is related to the seeking of consent in general. The person obtaining consent would have observed one being undertaken.
- The consent form is appropriate.

Storage and disposal of organs

- AMNCH also dispose of organs for Naas General Hospital. Naas General Hospital do not consider that they have appropriate facilities for the storage of organs removed at post-mortem examination. Therefore the organs are transferred to the AMNCH for examination, storage and disposal. The transfer is carried out appropriately through the laboratory. The tracking and documentation in regard to this process is excellent.
- Naas General Hospital retains responsibility to inform and ascertain the family's wishes regarding disposal when the examination of organs is complete or the coroner has agreed to their disposal.

Bereavement support services

- The General Manager and Director of Nursing are responsible for the management and delivery of the very limited bereavement services.
- The hospital is a Hospice Friendly hospital.
- There are dedicated relatives' rooms on the ward area with an external telephone line.

Information leaflets

- A bereavement information pack is provided including advice about the death certificate and registering the death, an explanation of what happens to the deceased's body after the relatives have left the hospital, and contact details for national and local bereavement support agencies and the hospital switchboard. *Good practice*.

Areas for improved focus/action

- There is need to review and if necessary update policies and standard operating procedures as a matter of urgency.
- It is also important that appropriate mechanisms are in place to ensure the documents are regularly reviewed in future and there is a need for some additional policies and standard operating procedures to be put in place. Action to embed policies firmly within the organisation is also needed.
- The mortuary is located in a port-a-cabin and the planned redesign is sorely needed.

National Maternity Hospital, Holles St.

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	**176** organs were retained in **15** cases of which **4** cases were CPM		0
Perinatal	**13,574** organs	**100** organs	0

Comments: It is evident that there are a considerable number of organs still stored at the National Maternity Hospital for this period. Direction is needed from the HSE with regard to organs currently held. The National Maternity Hospital is in line with two other validated hospital that did not take action to dispose of organs until further definitive guidance had been issued after the meeting in March 2004.[2]

A new consent form was instituted in March 2000 (no more than 6 cases were completed between January and March). Since this time the hospital reports that all post-mortem examinations have been completed with explicit consent including permission to retain necessary organs. Prior to this consent was obtained but documentary evidence may not be to hand. However, it should be noted that although it is good practice to sample all organs for histology it is indeed unusual practice, when comparing against other hospitals audited and validated as part of this process, post 2000 to still retain organs post histology/report writing even with consent. The valid explanation provided by the hospital in relation to the above is that *"organs currently retained in NMH post 2000 reflect either:*
a. Parents having requested to bury the organs themselves and failing to contact the hospital;
b. Coroners case where permission to bury the organs has not yet been received"

Table B Post 2000	Hospital Post Mortem	Coroners Post Mortem	Education/Research
Adult and Perinatal	**673** (no differentiation between Hospital and Coroner PM's available)	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	**322** sets of organs[20]
Post Mortem Post 2000	**272** sets of organs

**Tables A,B and C are updated as of May 2009.*

Policy and practice

- There was no evidence of policies relating to organ retention and post mortem practice. However, there were laboratory procedures for perinatal autopsy above and below 500 grams.
- There were a small number of relevant documents e.g. a list of frequently asked questions about perinatal post-mortem examination (autopsy), which was version controlled but with a 2003 date.

Record Management and Tracking

- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.
- Many documents and logs were in paper format and would benefit from being computerised.

Communication with families-Consent

- Consent is always sought by a doctor.
- Consent training is mandatory (usually at induction) and participants are signed off as designated doctors who have received training and can obtain consent.
- Having said this, the practice is unusual at Holles Street in regard to organs that are removed at post-mortem examination but are not disposed of as soon as they are sampled for histology. What is included

in the information to be delivered to families in the hospitals training is questionable i.e. terminology such as parts or sets of organs. This was investigated further and reported to the hospital that the consent form was confusing and uses obtuse language and needs to be reviewed. The consent form had been reviewed and detail is now clear. *(see Note at end of NMH section)*

- A consultant pathologist delivers the consent training or a power point presentation is observed and the doctor signs to confirm that they have watched it and is clear about the process of seeking consent. This is a very detailed and informative presentation.
- If a doctor has not completed this process, should he choose to take consent for a post-mortem examination, the consent would not be accepted in the mortuary. There is zero tolerance on this issue.

Storage and disposal of organs

- The storage for the pre 2000 organs is acceptable, in a secure remote storage room in the grounds of the hospital. However, sensitive disposal should take place, after further Health Service Executive guidance is issued.
- For the more recent cases the storage was not acceptable; some were in a cupboard and on a shelf while the rest were on the floor. This is not appropriate. There is insufficient space and furnishings and equipment are archaic.
- On a return visit by the audit team it was noted that a new post mortem examination room with dedicated facility for organ storage had been built and put into use.

Bereavement support services

- There is a newly appointed bereavement support midwife.
- Chaplaincy are quite heavily involved with bereavement services as is the social work department.
- The viewing area is poor and in need of refurbishment and has poor external access, although plans are in place for modernisation.
- Ward staff are very sensitive to the needs of bereaved parents.

Information leaflets

- There is a variety of booklets but no bereavement pack.

Areas for improved focus/action

- Review and implementation of policies.
- Sensitive disposal of pre 2000 organs currently held in line with past and future HSE recommendations.
- Review the process relating to the retention of organs.
- Stop the use of ambiguous wording i.e., sets of organs, and parts of organs. Be clear. (see Note)
- Consent form needs to be reviewed.(This has now been reviewed, see Note)
- Bereavement literature should be reviewed and a bereavement pack introduced.
- Review strategies to carry out appropriate bereavement roles.

Note: Following the Audit team visit to NMH a review of the consent form was undertaken and it was felt it could be clearer. The consent form and Frequently Asked Questions were changed appropriately and this has been reviewed by the audit team.

Our Lady's Children's Hospital, Crumlin (OLCHC)

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	**70** organs still retained	**81** organs still retained	**4** for medical education and medical research
Fetuses	0	0	0
Comments: In line with two other validated hospital that did not take action to dispose of organs until further definitive guidance had been issued after the meeting in March 2004.[2] Direction is needed from the HSE with regard to organs currently held.			
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	**2** organs still retained	**14** organs still retained	**22** for medical education and medical research (6 organs from 2 cases from CUH) plus **1** set[1] of organs from another jurisdiction.
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	• **81** organs have been disposed of. • **1** unidentifiable fetus retained from the period before the year 2000 had been disposed of by the hospital.
Post Mortem Post 2000	• **64** organs have been disposed of.

Policy and practice

- The hospital has considered its policies in respect of current national guidelines for the storage, removal, retention and disposal of organs through a formal review of relevant policies and standard operating procedures. The hospital has fully implemented revised policies, which are of a high standard. *Good practice.*
- All policies are version controlled *Good practice.*
- Revised policies have been accepted by the Senior Management team and ratified accordingly. *Good practice.*

Record Management and Tracking

- The organ retention database of 1999-2000 forms the basis for the entire system of consent taking at the hospital; this was used on the review pro-forma as an example of the ways in which learning from events is fed back into the organisation in order to support continuous improvement and on-going quality assurance in obtaining consent. The processes described are integral to the hospital's clinical governance system. *This is very good practice.*
- There is no formal process for monitoring effectiveness and retention levels of the information disseminated to the bereaved at the time of post-mortem examination. However only the consultant histo-pathologists are involved in the information delivery process so the hospital is confident that the information given is accurate and appropriate. *This practice is excellent* however this does not negate the need for audit; in the spirit of openness, honesty and transparency.
- The audit team was informed that the pathology technician audits the organs store, which is *good practice* as it makes it more likely that the patient's wishes will be carried out. This still does not mean that the process itself should not be observed periodically for audit purposes.

- In the event that information provided to bereaved people concerning post-mortem examination was poorly delivered this would be reported and investigated as an adverse incident through the complaints procedure. *Good practice*.
- Processes surrounding the management of the storage, use, removal retention and disposal of organs are monitored through the adverse incident reporting systems, as are processes for obtaining consent to post-mortem examination and the provision of support to bereaved relatives. There is a regular audit of organ stores by the senior pathology technician to ensure compliance with parental wishes and this is supported by a range of paper records surrounding each post--mortem examination as documented in the 'Mortuary Procedures' .[21] *Good practice*.
- Circumstances where information about the removal, retention and/or disposal of organs had been poorly delivered, or where the body of a deceased person appeared to have been inappropriately handled, would be investigated as an adverse incident as part of the laboratory complaints procedure.
- The record keeping was all in place and comprehensive, although control of the organ register needs to be tightened. One person should take overall responsibility and double check each form as filed and ensure that all documentation is kept up to date - i.e. when and how organs are collected / returned / disposed of - as there was 2 forms of recording. There was an instance where only one form of log had the relevant information and perhaps one record is enough to avoid confusion if that record is backed up.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families -Consent

- Families have the opportunity to remain in contact with the pathologist in the weeks following a post-mortem examination and bereaved people are also invited to return to the hospital and comment on their experience through the Patient Support Unit. *Excellent practice if not replicated in other hospitals it should be.*
- The pathologist is always involved in taking consent to post-mortem examination, and is ultimately responsible for ensuring written informed consent to post-mortem examination is sought. He may be supported by another doctor or by a nurse from time to time. No other health care professionals are involved in this process. *Good practice.*
- The pathologists have received training in obtaining consent to post-mortem examination and are professionally qualified to conduct post-mortem examinations.
- A brief description of the process for obtaining consent to post-mortem examination was provided:

  'The process for obtaining consent to post mortem is described in the operating procedure LP-MORRegAut. In OLCHC, the pathologist on duty meets the family to discuss the procedure and complete the relevant forms before the post mortem begins, whether the examination is performed under the direction of the coroner or not. The clinical staff caring for the child therefore introduce the subject of a post mortem and make an arrangement for the pathologist to speak with the family directly.'
- Specific staff have been trained to obtain consent and provide full information about post-mortem examination practice and there are systems and processes in place to ensure that this training is kept up to date. The process was briefly described in the following manner:

  'All NCHDs receive instructions regarding post mortem consent and information as part of twice yearly induction programme. All doctors encouraged to involve the pathologists early, before discussion of post mortem has begun if at all practical.' Excellent practice.
- In addition there is a Request for Autopsy form, which has a helpful distribution list attached and includes information about the removal, storage, retention and subsequent disposal of organs retained at post-mortem examination. Once again this is appropriately version controlled.
- OLCHC ensure that the paediatric pathologist always obtains consent for the post-mortem examination, which is enormously helpful to families. It is also highly noteworthy that the concept of making a 'request' for autopsy as opposed to 'obtaining consent' carries with it much softer connotations which are helpful to the bereaved people and professionals alike. *This is excellent practice.*
- As was noted above the same staff are involved in speaking to relatives about post-mortem examination. Once again *excellent practice.*

Storage and disposal of organs

- Practice at the hospital since 2000 is where possible to delay the funeral and return organs to the body prior to burial.
- The hospital describes arrangements at Newlands Cross Cemetery, where they had purchased a number of plots allowing them to bury either children or organs. *Good practice*.
- There are arrangements in place to ensure that children or organs buried in the plot are appropriately logged, and in accordance with the standards of Newlands Cross Cemetery. *Good practice*.
- Storage is appropriate.
- There are a number of places where organs removed are noted - e.g. consent form - electronic -hard back copybook - with evidence of mode of disposal / return of all organs. All data are present on one form or 2 or all forms in most cases.

Bereavement support services

- There is a Death, Dying and Bereavement Group chaired by the Deputy Director of Nursing, which reports to the Hospital Executive Committee regarding practice and quality improvements to ensure the changing needs of parents and families are met. Although it has met on several occasions it has produced little of practical benefit to date, according to the minutes and other evidence produced. Indeed evidence would suggest that bereavement support has decreased since 2000, especially the level of social work service support.
- Sometimes non-Irish nationals for cultural reasons have asked the hospital staff to arrange for burial of their child. The patient support unit also meets these requests. The patient support unit, in conjunction with the medical social worker, tries to involve the family in planning as much as possible and to have family, friends or relatives involved where possible. Written consent is sought and obtained to arrange the burial. Burials have taken place in the hospital grave at Newlands Cross (Cemetery) and chaplaincy staff and/or medical social workers attend with mortuary staff. *Good practice*.
- There is a multidisciplinary approach to the provision of bereavement services and all members of hospital staff are involved in this process.
- However, the support offered to bereaved families varies throughout the hospital. In oncology and cardiac wards the support is far superior to that given to the families of other children who die in the hospital, and may include flowers after death, first Christmas card, first anniversary card.
- There is a remembrance day held for children and a very nice book of remembrance in the chapel. *Good practice.*
- There are very good quiet places/breaking bad news areas. Each ward area has an individual space that can be utilised. *Good practice*.
- 'Suaimhneas' is a room that has been developed specifically for medical and nursing staff to meet families. *Excellent practice.*
- The viewing area contains removable religious symbols and sacred texts are available on request.
- The area is wheelchair accessible. *Good practice.*

Information leaflets

- OLCHC has a documentation guide to post-mortem examination of a child, which is available for parents or guardians of children who have died in the hospital. It is very comprehensive and explicit about the possibility and procedure for retention of organs at post-mortem examination. *Excellent practice.*
- Associated with the comprehensive information leaflet there is a very helpful pre-autopsy checklist for the consultant pathologist, which is appropriately version-controlled *Good practice.*
- The social work department has generic written information, which is given to families on an ongoing basis and customised to be appropriate to each family's needs. To assist social work staff the department has the Irish Sudden Death Information folder '*Information for parents and close family at the time of a child's death*' which was introduced 15 years ago and updated in 2006. A range of material on the grief of parents, grandparents, and siblings is available.
- The oncology unit also provides a comprehensive leaflet 'Precious Times' and there is a wide range of national leaflets available for family and close friends following the death of a child at the OLCHC. These are often quite specifically related to particular illnesses.

Areas for improved focus/action

- The hospital should review the status of the pre 2000 retained organs and follow national guidance with regard to their disposal (in line with two other validated hospital that did not take action to dispose of organs until further definitive guidance had been issued after the meeting in March 2004).[2]
- There should be a review of the recording mechanisms for the retention of organs at post-mortem examination to ensure that, if recording is in duplicate, both systems are filled in concurrently, removing the possibility of error.
- There must be a consistent bereavement support approach to all child deaths.
- There is no multi faith room and this should be reviewed.
- On some occasions there is more than one dead child in the hospital but only one mortuary viewing area. There have been on occasions 3 dead children at one time in the hospital. The hospital's ethos is to facilitate the family's wishes surrounding the last hours with their baby/child, which is *excellent*. However, in these cases the facility does not accommodate this well as one family has to be in the entry hall and the other in the viewing room or relocation has to take place. This is not fair, appropriate, private or dignified. Contingency plans must be put in place.
- Bereavement training has lapsed in the hospital and this should be reviewed.
- There is evidence of multi departmental working, and seeking consent and mortuary practice is of a *very high standard*. However, it has to be said that the bereavement service is better on paper than it is in reality. For example, leaflets for parents and staff are ten years old. This is constantly stated to be 'under review'. Action needs to be taken following the reviews.
- There is a proposal to appoint a Bereavement Services Coordinator and it is to be hoped that this post will be established as soon as possible.
- There is involvement in 'Hospice Friendly Hospitals' programme and it is hoped this will provide impetus to support services. The huge disparity of support services, good in cardiology and oncology but non-existent elsewhere, must be difficult for families to understand.
- Service planning is being reviewed; as part of this it is essential that positive and improving action is taken, as many services have been revoked.
- There is a need for different faiths and cultures to be integrated within the hospital, as there is not an embedded multi faith and multi cultural ethos at present.

Our Lady's Hospital, Navan

All post-mortem examination histology is sent to Connolly Hospital and all post-mortem examination specimens/organs are transferred to Connolly through the hospital laboratory and sent the following morning via appropriate transport with appropriate insurance (This should however also be recorded in the mortuary). Organs are also returned to Navan once examined.

Validation Status – *Validated (√)*
Validation of Currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**5**	0
Children	0	0	0
Fetuses	0	0	0
Comments: These 5 organs are awaiting the coroner's response; although there are numerous recorded contacts made with the coroner with regard to these organs, as yet no response has been forthcoming.			

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	0
Post Mortem Post 2000	0

Policy and practice

- The hospital has not considered its policies in respect of national guidelines for the storage, removal, retention and disposal of organs, and had not formally reviewed existing policies, but indicated that it anticipated doing so within 6 months.
- Policies directing the process for obtaining consent to post-mortem examination were in place.
- The hospital identified consent guidelines and a sample consent form is under review.
- The technician has his own informal standard operating procedure, which should be built on and formalised. The technician also has in place an excellent confirmation of the post-mortem examination request from the coroner (form C71 faxed from coroner) confirming who identified the body and the circumstances of the death. A recently appointed pathologist has started covering sessions at the hospital and is reviewing the documentation.
- Whilst the hospital does appear to have systems in place to identify instances of poor information giving in relation to post-mortem examination, they did not describe how the lessons learned from incidents would be fed back into the organisation to stimulate a cycle of continuous improvement.

Record Management and Tracking

- The registers and logs are in place and to a *very high standard,* however there are no inter hospital working logs (i.e. Navan /Connolly) and the mortuary would be enhanced by greater use of IT.
- If an organ is transported to another hospital other than Connolly (e.g. an organ to Beaumont for neurological examination), it is taken by the technician in appropriate transport, the examination is done whilst the technician waits and then the technician returns the organ in appropriate packing and appropriate transport to the hospital. *Excellent practice.*
- The hospital does not monitor the effectiveness and retention levels of information provided to bereaved people at the time of post-mortem examination. However, if information regarding post-mortem examination was provided in a poor manner, and the incident was reported, the hospital would pick this up through the adverse incident reporting process, which would lead to the complaint/incident being reviewed and remedial measures being implemented where necessary.

- The hospital does monitor instances in which the process surrounding organ retention, consent and the support provided to bereaved relatives was poor, utilising the adverse incident reporting system and has taken steps to quality assure the service provision to a consistent standard.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families –Consent

- Consent always obtained by a consultant or non consultant hospital doctor (NCHD).
- The consent form is wholly inadequate; it consists of:

> *'I hereby give consent to the performance of a post mortem examination on … '* signed, relationship, witness, date'[22]

This indicates a lack of observance of HSE 2002 guidance.[9]

Storage and disposal of organs

- If an organ is to be retained from a coroner's post-mortem examination, the family will be notified by the coroner. After the inquest, hospital policy requires an Anatomical Pathology Technician to liase with the coroner to contact the relatives with regard to the disposal of the organ.
- Organs are stored appropriately.

Bereavement support services

- There is no formal bereavement service.
- The hospital is participating in the 'Hospice Friendly Hospital' Programme, which is aimed to improve care around dying, death and bereavement.
- Some ward areas have dedicated relatives' rooms with an external telephone line and the pastoral care room is also available.
- There is a viewing area within the mortuary facility with removable religious symbols and wheelchair access. Viewing facilities are a little drab but adequate, clean and spacious.
- A pathology technician provided information regarding bereavement support.
- There is no social work service provision.
- Chaplains are available for services but there is no structured bereavement service and minimal literature available for bereaved relatives. There is a need to strengthen multi cultural awareness.

Information leaflets

- Bereavement information is provided including advice about how to contact a funeral director; and advice about registering the death and the death certificate; together with a checklist of people who may need to be informed about the death.

Areas for improved focus/action

- There is a need to introduce proper policies and standard operating procedures with immediate effect. The hospital conceded that they were only just beginning implementation of revised documentation including version control. Comprehensive policies covering all relevant areas are needed.
- There is a need to review recording systems, including inter-hospital transfers and the possibility of computerisation. Standard operating procedures are needed to underpin the policies. However, work is underway and there is well-documented progression, i.e. ratification/draft/version control.
- There is a need to review and implement a suitable bereavement service and to develop a bereavement pack.
- Facilities are of a good standard, although the refrigeration would benefit from being renewed.

Portiuncula Hospital, Ballinasloe

Validation Status – *Validated (√)*

Validation of Currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	**1**	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	0
Post Mortem Post 2000	**17** organs **30** fetus' disposed of pre 2000 and **56** fetus' post 2000

Policy and practice

- Policies and standard operating procedures all of a *very high standard* and all version controlled.
- However many review dates have been missed and there were also a number of hand written procedures that were in need of reviewing.

Record Management and Tracking

- There was an *excellent level* of detail in the log and registers in the mortuary.
- Documents are all in hardback format.
- *Excellent* tracking between mortuary and laboratory.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families –Consent

- It is always a doctor who seeks consent to post-mortem examination and the consent form was appropriate.

Storage and disposal of organs

- The storage of organs in the office of the mortuary was poor due to lack of space.
- The office was seriously overloaded.
- There is a need for a separate lockable storage cupboard.

Information leaflets

- The hospital has a leaflet about the post-mortem examination.

Bereavement support services

- There were reasonable viewing areas, which were wheelchair accessible.
- The chaplaincy department is very involved with the bereaved and staff support. Social work is involved with maternity and other areas.

Areas for improved focus/action

- It would be beneficial for the mortuary records to be in the same electronic format as the laboratory system.
- There is a need to review the mortuary facilities/equipment, much of which needs modernisation.

- There needs to be a greater awareness of the multi cultural aspects of Ireland, particularly in view of the large immigrant population nearby.
- Integration of the medical social work department with regard to bereavement services.
- Modernisation of the mortuary facilities and appropriate storage for organs.

Rotunda Hospital

Validation Status – ***Not validated at the time of the audit visit in December 2007. (see overleaf)***

- The audit team was not able to validate the Rotunda hospital.
- There are a number of serious concerns with regard to the organs held at the Rotunda Hospital: -
    1) Consent.
    2) Policy and practice.
    3) A large number of retained organs pre and post 2000 still awaiting examination.
    4) Poor record management and tracking, including poor documentation and record keeping.
    5) Misleading information leaflets, re post-mortem examinations.
    6) Incomprehensible, incomplete and inaccurate data with regard to retained organs and significant omissions in the facts pertaining to organ retention and the disposal of organs.
    7) The storage of a significant amount of organs for prolonged periods.
    8) The number of organs routinely retained during a post-mortem examination.
    9) There was a significant delay in the sensitive disposal of organs.

The audit team's conclusion is that the Rotunda hospital has failed to comply with the December 2002 HSE guidance.
The Health Service Executive were alerted to the concerns of the audit team as the hospital could not be validated following the second visit on the 7th of December 2007.

In December 2007 and January 2008, the audit team made further visits to the hospital, culminating in the Health Service Executive establishing a separate investigation to report on the Rotunda Hospital.

Rotunda Hospital second audit visit

Validation Status – *Validated (√) only February 2008 to 12th May 2009*

Validation of currently retained organs

The Rotunda Hospital was visited again by the audit team after the completion of the Carter Report (June 31st – July 2nd) to review practice from December 21st 2007 to 12th May 2009.

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adults	0	0	0
Perinatal	2492 organs plus 65 organs that have been identified in blocks. (blocks have not been searched).	126 organs	17 organs retained for education purposes.
Comments: The Rotunda Hospital in line with two other validated hospital that did not take action to dispose of organs until further definitive guidance had been issued after the meeting in March 2004.[2]			

Table B Post 2000	Hospital Post Mortem	Coroners Post Mortem	Education/Research
Adult	0	0	0
Perinatal	549 organs plus 287 organs retained in blocks.	74 organs	6 organs retained for education 167 organs retained for research.

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	Accurate data cannot be supplied
Post Mortem Post 2000	Accurate data cannot be supplied up to the end of 2007 The number organs returned in 2008 was 41 and 5 organs that were not returned but retained in blocks. The number organs were returned in 2009 was 9 and 1 organ retained in a block and not returned.

Policy and practice

- Hospital practice relating to the removal and retention of organs at post-mortem examination since December 21st 2007 is in line with the hospital booklet 'post-mortem' (revised February 2008) an information booklet for parents on post-mortems. In the cases where organs are retained temporarily from a baby only 2 or 3 organs are have been retained.
- Revised policies will now be overseen by the post-mortem quality group; a new post-mortem policy is in place and is appropriate as of April 2009. However, this policy is only acceptable if the content laid out in it is adhered to. The policy is version controlled.
- The audit team are confident that the hospital is in a position to respond with accurate information to families with regard to post-mortem examination completed post Dec 21st 2007.
- Retrospective blocking took place between December 21st 2007 and February 2008.

Record Management and Tracking

- The new electronic system that links the laboratory and the mortuary information, including information regarding the retention of organs and the post-mortem examination forms since Jan 2009. This system is supported by a hard back book logging system until the new system is embedded.
- The organ retention database is now complete. Those who make contact with the Rotunda Hospital regarding cases pre 2000 and post 2000 to the 21st Dec 2007 if organs are retained will be in a position to receive that information, however if organs have been retained and disposed of the records are not sufficiently accurate to give definitive information regarding the number of organs retained and disposed of. Post December 21st 2007 the audit team are confident that all information is available.

- The database format presented to the audit team was changed between 2008 and 2009; the 2008 was more informative and the hospital were advised to revert to this system on 30th June 2009.
- The hospital were also advised to add another field to the data base in relation the retention of an organ temporarily where the funeral is delayed for the organs to be returned to the body.
- The bereavement and medical notes completed relating to communication with the family were well completed.
- All post-mortem examination case files from Dec 21st 2007 through to the 12th of May 2009 have been reviewed by the audit team.
  i). All documentation was completed in a timely fashion during this period.
  ii). All histology blocking took place in a timely fashion during this period
  iii). All organs were sensitively disposed of in a timely fashion during this period.
  iv). Most cases had comprehensive bereavement and social work notes.
  v). Some consent forms remained ambiguous/completed incorrectly. While this did not significantly impact on the overall consent for post-mortem in these cases, further improvement was required.
  vi). In one coroners case there was not the hospital coroner's acknowledgement for that was presented to the audit team.
  vii). In a further coroners case consent had been sought but this then had coroners case written on it.
  viii). Another case phone consent had been sought, the notes were unclear as to why this was the case as the mother was an in patient that day. There were 2 notes regarding contact with the mother but no notes relating to the conversation.

Communication with families' –Consent

- The consent form pre Feb 2008 was misleading, the superseding consent form was an improvement however there were a number of inconsistencies and area where the consent for had been filled in inaccurately in some cases, especially relating to cases where a superficial examination took place. A new consent form has been in place since April 2009 (however there were only 2 cases where this had been used). This form if completed correctly should alleviate previous deficiencies.
- A small number of superficial examinations took place without consent between December 21st 2007 and February 2008. Since February 2008 all cases where a superficial examination has taken place a consent form has been completed.
- One 2009 case was raised with the Master with regard to ambiguity regarding the retention of an organ and the communication with the family concerned.
- There are a small number of cases where once the organs has been retained and blocked that there is nothing to return to the family. In most of the cases the family has been informed, this is not always the case.

Storage and disposal of organs

- Storage of organs in the hospital is appropriate.
- Disposal of organs between January 2008 and May 2009 are requested on appropriate forms, choices are given and these instructions are carried out.

Information leaflets

- A post-mortem leaflet and a bereavement leaflet had been updated in February 2008; practice was in line with what is written post February 2008.

Areas for improved focus/action

- The hospital should review the status of the pre 2000 retained organs and follow national guidance with regard to their disposal (in line with two other validated hospital that did not take action to dispose of organs until further definitive guidance had been issued after the meeting in March 2004).[2]
- The HSE should ensure that the Rotunda Hospital is audited 6 monthly for the next 2 years to ensure consent compliance and conformity with national standards.
- Where organs have not been disposed of and the family have given explicit instructions about choices, these families should be contacted and informed that this had not taken place and that once they have made contact their wishes should be adhered to.

Sligo General Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	
Post Mortem Post 2000	• 25 organs from 24 cases. In 4 cases the organ was returned to relatives, all the other organs were disposed of by incineration . • There is no record of the number of foetal losses at the hospital the audit team were informed that all fetus' are returned to the mother or buried by the chaplaincy department in a local cremetry where the burial place is recorded.

Policy and practice

- The policies and standard operating procedures were very limited. The hospital has stated that they had reviewed the policies in respect of current national guidelines for the storage, removal, retention and disposal of organs.
- This documentation had been formally reviewed but at the time of writing these reviewed and revised documents had not been accepted at Executive Management level and there was no plan to submit them for ratification within the next 12 months.
- Accordingly the hospital indicated that their policies were partially implemented. However only four policies and standard operating procedures were presented to the audit team, which were all version controlled.

Record Management and Tracking

- All logs were kept in a hard back format and were of a reasonable standard.
- Sligo General Hospital does not currently monitor the effectiveness and retention levels of information provided to the bereaved at the time of post-mortem examination and incidents of poor information giving would not routinely be identified and investigated as an adverse incident and the process was described on the audit tool, as follows

  'Any incidents reported would be forwarded to the risk management advisor. After further investigation the RMA would report to the General Manager' .[23]
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- There are dedicated personnel nominated to speak with a family should an organ be retained.
- The doctor is always involved in taking consent, although other professionals may be involved as necessary.
- These might include the pathologist, nurse, midwife, social worker, chaplain or other health professionals.

- Ultimately the doctor is responsible for obtaining written informed consent to post-mortem examination. *Good practice.*
- Sligo provides training for specific staff to obtain consent and to provide full information about post-mortem examination. The process was described, as follows;

  'Consultants provide information to relatives concerning post mortem practices. All Doctors are trained during the course of their medical training to take informed consent' .[23]
- The hospital indicated that staff had received training in obtaining informed consent to post-mortem examination. The nature and extent of this training is unclear however, and based on previous responses there is likely to be a reliance on what doctors have learned in their earlier medical training.

Storage and disposal of organs

- Disposal was by incineration, which is ***wholly inappropriate by today's standards*** however this practice ceased in 2003. Prior to September 2002 the audit team were advised that the families were not informed of the retention of organs. Since September 2002, if the family requested burial of an organ these wishes were carried out.

Bereavement support services

- Support is given to families of stillborn and neonatal and paediatric deaths by nursing staff in these units.
- The role of the social work department is unclear. Where there is a need for Social Work involvement then there is involvement from the Social Work Department.
- The chaplaincy seems to fulfil a mainly sacramental role and becomes involved only when requested.
- There are no formalized services for families, apart from a remembrance service. However, there was little information provided about this.
- The ward/sister's office is used as a relatives' room and has an external phone line.
- There is a viewing area containing religious symbols, removable apart from a cross on the wall. Symbols and sacred texts are provided on request and the area is accessible to wheelchair users.
- The Hospice Friendly Hospitals project is working in this hospital although no one was available to see the audit team.

Information leaflets

- No bereavement literature was available.

Areas for improved focus/action

- Policies and procedures should be reviewed.
- Logging system should be reviewed and introduction of electronic format similar to laboratory would be beneficial in post mortem.
- Training received by doctors during medical training (if there is any) is not sufficient with regard to the seeking of consent for post mortem examination. This should be reviewed including the provision of specific training.
- There was no evidence of a bereavement service; this should be reviewed.

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Note: (There were a number of specific issues highlighted by the audit team to the HSE that required immediate action ahead of the publication of the report. One of the issues highlighted was the practice of the disposal of organs by incineration at Sligo General Hospital. The following has been noted by the audit team in relation to the specific issues raised.)

- It was confirmed in writing, on 9th January 2009, by Sligo General Hospital to the HSE that the practice of disposal of organs by incineration ceased at the hospital in 2003.

St. Columcille's Hospital, Loughlinstown

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	**4**	**5**	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**2**	**60+ 1** set[24]	**2 (**coroners case**)**
Children	0	0	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	
Post Mortem Post 2000	412 organs by burial or cremation.

Policy and practice

- The documentation with regard to policies is exceedingly poor. There are a small number of documents which have never been formalised or ratified or version controlled.
- Many documents are still in draft form (one draft was dated 2005); some have hand-written corrections, some of which have in turn been amended. However, the in-house leaflet on information for families does mention organ retention.

Record Management and Tracking

- Very good electronic logs are held, just require the exact detail of the organs removed and retained.
- There is also a very comprehensive log covering the post-mortem liaison officer's work and that of the return of organs section relating to the retention of organs at post-mortem examination. *Good practice.*
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- The post-mortem liaison officer primarily communicates with the bereaved although with regard to removals it would be the Anatomical Pathology Technician.
- The consent form is appropriate.
- A non-consultant hospital doctor would seek consent for a post-mortem examination; the training is at induction and would appear to be generic and minimal.

Storage and disposal of organs

- Storage of organs is appropriate.
- Disposal of organs is appropriate.

Bereavement support services

- Virtually all bereavement support and all information surrounding the retention and return of organs is provided by one post-mortem liaison officer.
- Chaplaincy will meet with relatives upon request.

Information leaflets

- None-were made available, other than those previously stated under policy and practice.

Areas for improved focus/action

- An urgent review of policies and standard operating procedures is needed.
- Review staffing arrangements with regard to the return of organs retained at post-mortem examination; the post-mortem liaison officer is single handed and in her absence no return of organs took place and nobody was available to deal with this issue. This requires attention given that St. Columcille's has one of the largest throughputs of post-mortem examinations in the State.
- Improve social work input to bereavement services.
- The mortuary facilities are in need of updating including refrigeration, an additional dissection table or as a minimum a dividing screen to avoid errors. The viewing area also warrants some modernisation.
- Review training provision with regard to seeking consent.
- Clarification should be made with regard to the role of nursing administration in the receiving of bodies, as currently it would appear to be a hindrance in the process.

St. James' Hospital

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**2**	**69**	0
Children	0	0	0
Fetuses	**1**	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	**346** organs
Post Mortem Post 2000	**415** organs + **1** set[1]

Policy and practice

- The hospital has policies in place, although some need updating and cross referencing with other policies and some are in draft, which need to be completed or their status as drafts made clear. However in general the documentation is of *a very high standard*.
- The hospital has considered their policies and procedures in relation to current national guidance.
- The Autopsy and Bereavement Committee have accepted the policies.

Record Management and Tracking

- The logging, tracking and recording of cases and retained organs are of an exceptionally high standard.
- There are good electronic pathology systems. However there are elements in the mortuary that need to be updated.
- Exceptionally effective systems are in place to monitor the provision and delivery of information at the time of post-mortem examination.
- Incident reporting and learning are integral to the management of the hospital. Adverse incidents are discussed individually and a quarterly trend analysis is produced and acted upon.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.
- The hospital should be commended for the high standard of their policies; standard operating procedures and record management are exemplary.

Communication with families-Consent

- All consent is taken at doctor level. (Consultant/medical team)
- The pathologist and bereavement social worker give interns training during the week before they start their duty in the hospital. All doctors are given 6 monthly updates in January and July.
- Training with regard to seeking consent is currently part of medical staff induction; nurse managers also provide training sessions. *Very good practice*.
- The histo-pathologist also provides training. Consideration is currently being given to providing additional training for nurse managers.
- There is also an excellent process in place with regard to explaining the need for a coroner post-mortem examination.
- The consent form is appropriate.
- The process of delivering information surrounding the post-mortem examination process in the A & E department is excellent - a fine example of multi disciplinary working and of an *exemplary standard*.

- There is much interaction with families on the hospital site; however the viewing rooms and the chapel in the mortuary facility are underutilised.
- Consent and communication are evidently embedded within the hospital ethos.

Storage and disposal of organs

- The storage of organs is appropriate.
- The neuro-pathologist from Beaumont visits for one session a week to examine brains in situ rather than the brains having to be transported. *This is good practice.*
- The mortuary facilities are of an *exceptionally high standard.*
- Disposal of organs is as per the families' wishes. If organs are disposed of by the hospital the method is cremation and then the cremated organs is buried in a hospitals plot so as the organs can be located if necessary. This practice is different to other hospitals and the HSE guidance, as burial was the recommendation.

Bereavement support services

- The medical social work team is integral to bereavement services with clearly defined roles and responsibilities with regard to support for families and the retention of organs at post-mortem examination.
- The mortuary staff also play a significant part in the bereavement process, specifically surrounding the post-mortem examination process. There is also a mortuary secretary who plays a significant role.
- There are exceptionally high standards of mapping care routes for the bereaved and those undergoing a post-mortem examination, which include identification of areas that need to be strengthened.
- There are dedicated relatives' rooms as well as some areas such as sister's offices that are utilised as quiet spaces for bereaved relatives; there is a general relatives' room in the accident and emergency department.
- There is an excellent bereavement pack provided to the relatives of the deceased patient.

Information leaflets

- There was an excellent bereavement pack and supporting information available to bereaved families.

Areas for improved focus/action

- The viewing/chapel area is only used for the identification of a body. This state of the art mortuary facility is grossly under utilised and should be reviewed.

St. Vincent Healthcare Group - (incorporating St. Vincent's University Hospital (SVUH), St Michael's Hospital (SMV) and St. Vincent's Private Hospital (SVPH)

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	(HPM) Hospital Post Mortem	(CPM) Coroners Post Mortem	Education/Research
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	**5**	**40**	0
Children	0	0	0
Fetuses	0	0	0

Table C	Organs Disposed of Since 2000
Post Mortem Pre 2000	
Post Mortem Post 2000	**503** organs disposed of in 423 cases.
Other	The healthcare group liaise with the National Maternity Hospital concerning arrangements for the burial or cremation of stillborn babies and neonatal deaths and ensure compliance with the National Maternity Hospital policy where appropriate to facilitate appropriate arrangements in keeping with the expressed wishes of the family.

Policy and practice

- The healthcare group has considered its policies and standard operating procedures in relation to current national guidelines for the storage, removal, retention and disposal of organs. *Excellent practice.*
- These policies and standard operating procedures have been formally reviewed, accepted at Senior Management level and ratified accordingly, so that revised policies are now fully implemented. *Excellent practice.*

Record Management and Tracking

- There is an excellent electronic log and database. *Excellent practice.*
- The healthcare group does not monitor the effectiveness and retention levels of information disseminated to bereaved people at the time of post-mortem examination but if it was reported that the information given to bereaved people concerning post-mortem examination practice had been poorly delivered this would be investigated as an adverse incident through the risk management process.
- Where incidents are reported and areas of improvement are identified, procedures are amended as necessary, and lessons learned from the incident investigation are fed back into the organisation through the risk management process. This is integral to the organisation's clinical governance systems, and the Chairman of the Medical Board is responsible for ensuring that these clinical governance systems are robust.
- The hospital does monitor instances in which the processes surrounding the management of the storage, use, removal, retention and disposal of organs, consent to post-mortem examination, or the support given to bereaved people are poor, through its incident reporting systems, although no such incidents had been reported prior to the audit taking place.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.
- *The hospital should be commended for the high standard of its policy and standard operating procedures.*

Communication with families-Consent

- Within the St Vincent's Healthcare Group the doctor usually takes consent to post-mortem examination although a nurse may accompany him/her. No other healthcare professionals are involved in this process and the doctor is responsible for ensuring the appropriate written informed consent is obtained.
- However, as the doctor is not usually a pathologist s/he is not qualified to conduct the post-mortem examination itself and may not have seen a post-mortem examination being conducted.
- The consent process was briefly described as follows:

  'Medical team (Consultant or Registrar) discuss with and inform the family of post mortem procedure, organ retention and organ disposal. Written informed consent is requested for the post mortem examination. The family may refuse to consent to the examination or decide on a full or limited examination' .[25]
- The healthcare group has policies and standard operating procedures in place for dealing with post-mortem examinations and the following documents were specifically listed in the audit pro forma.
  - Post Mortem Policy and Procedures
  - Care Route for Hospital Post Mortems
  - Hospital Post Mortem Consent Form
  - Coroners Information pack for families
- St. Vincent's Healthcare Group has not trained specific staff to obtain consent and provide full information about post-mortem examination practice but has taken steps to ensure that existing procedures for obtaining consent satisfy national policy. This includes:

  'Training in obtaining informed consent is provided through Risk Management' .[25]

Storage and disposal of organs

- Storage of organs is appropriate.
- Sensitive disposal processes are *excellent* and well recorded.

Bereavement support services

- There was an evidence of engagement of staff at all levels with regard to dignity and respect for the bereaved.
- There are *superb facilities* for the bereaved (including mortuary facilities). The infrastructure at SVUH is a 'one stop shop' and is *an example to all hospitals* as a seamless service.
- The head social worker is responsible for the management of bereavement services.
- There is also an *excellent* bereavement support programme run by the social work department.
- There has been great effort put into all aspects of death and dying with regard to the Oratory and viewing facilities.
- Chaplains appear to provide a sacramental role and the audit team did not meet any on their visit.
- The hospital group has considered its policies in respect of national guidelines, and they have been ratified and fully implemented at SVUH.
- Relatives' rooms are available, and staff on ICU at SVUH should be commended for raising funds to create the new facility of a relatives' room.
- A viewing area is available with removable religious symbols, and sacred texts are supplied on request. The area is accessible to wheelchair users.
- At St Vincent's Private Hospital the relatives' room for breaking bad news is very comfortable and well designed, but the viewing room for the deceased was in need of minor refurbishment.

Information leaflets

- There is an *excellent* set of bereavement packs.
- St Vincent's has a good set of leaflets for distribution, including their own bereavement booklet and information to relatives regarding a post-mortem examination, including the consent form or coroners post-mortem examination information form, which also informs relatives of the possibility of the retention of tissue and organs and their choices around disposal.
- There is a need for joint working to ensure that all hospitals in the group have bereavement packs.

SVPH

- All the documents and standard operating procedures are the same as those for SVUH.
- No organs are retained and all post-mortem examination are transferred to St Vincent's.
- There is a post-mortem examinations' information booklet including information about the retention of organs.

SMH

- There were a couple of policies here, but they were in need of updating and version control, and need to be related to SVUH's policies.
- At SMH there is no area to break bad news to relatives other than a sister's office that has a multitude of other uses and is wholly unsuitable.
- The viewing facilities at SMH are old and lack space. The viewing area is cramped and tired. It has 4 bays where it would be more appropriate to have 2. Significant improvements could be made at little cost.
- There is a very large chapel but no multi-faith room.
- There is a relatives' room towards the entrance of the hospital that could best be described as a shrine.
- SMH has no leaflets available other than the coroner's information pack which was in a torn brown envelope and contained a consent form and booklet with information about post-mortem examination for relatives. There was nothing with regard to a hospital post-mortem examination or information about bereavement available for the families.

Areas for improved focus/action

- There is a need for distribution of policies and working practice between SMH and SVUH.
- SMH need to review and update the viewing area for the deceased.
- SMH should review the situation with regard to a relatives' room.
- There is a need for provision of bereavement packs at SMH.

Waterford Regional Hospital

Waterford Regional Hospital carries out post-mortem examinations on behalf of all hospitals and facilities in the South East.

Validation Status – *Validated (√)*

Validation of currently retained organs

Table A Pre 2000	**(HPM) Hospital Post Mortem**	**(CPM) Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0
Table B Post 2000	**Hospital Post Mortem**	**Coroners Post Mortem**	**Education/Research**
Adult	0	0	0
Children	0	0	0
Fetuses	0	0	0

Table C	**Organs Disposed of Since 2000**
Post Mortem Pre 2000	**2** organs in **1** case.
Post Mortem Post 2000	**4** organs from babies were disposed of 1 HPM and 3CPM **1** Adult CPM
Other	Organs retained between 1972- 2001 there are no disposal records. There is no log of fetal losses. However since 2001 **182** fetus have been buried in the hospital plot 'Angels plot' the audit team were informed that similar logs are kept at the other hospitals in the South East. If the baby is returned to the family there will be a note in the patient chart.

Policy and practice

- The hospital has considered its policies in relation to current national guidelines concerning organ retention. However revised policies have not yet been accepted by the Senior Management and ratified, although it is anticipated that this will happen within 12 months.
- The hospital stated that it has partially implemented changes in revised policies; however upon inspection there were very limited policies, of variable quality, and many were not properly version controlled and many have not been reviewed for a good number of years i.e. since 2002.
- There were a number of training lists with the policies to demonstrate that staff had been trained.

Record Management and Tracking

- The hospital does not currently monitor the effectiveness and retention levels of the information disseminated to bereaved people at the time of post-mortem examination. Furthermore, where the information provided to bereaved relatives is found to have been poorly delivered this would not be investigated as an adverse incident. In these instances the consultant pathologist would review the information and any learning would be fed back into the organisation through the Hospital Quality and Safety Committee.
- The hospitals had hard copy logs of a limited standard.
- The hospital does not currently specifically monitor the processes surrounding the management of the storage, use, removal, retention and disposal of organs, consent to post-mortem examination, or the level of support provided to bereaved people.
- Randomly picked cases were selected for tracking and followed through the system satisfactorily by the audit team.

Communication with families-Consent

- The consent form was appropriate.

- A doctor always seeks consent.
- The doctor who seeks consent is not a pathologist but will have witnessed a post-mortem examination being conducted
- An area consent policy is currently in circulation and under consultation.

Storage and disposal of organs

- Disposal is by 3 methods
    - Burial
    - Cremation
    - Return to the family
- There are good hardback records of the returns process.

Bereavement support services

- The maternity unit has evolved a system of supporting families and has a room parents can use and a bereavement room on the antenatal ward. Nurses within no formalised system provide limited support.
- Care is ad hoc and person dependent.
- Parents are provided with mementos such as footprints.
- There is no formalised bereavement service, or structure of support, across the hospital.
- The chaplaincy offers a 24/7 service and sees staff support as part of their brief. This is a valuable resource for staff and the observed interaction with patients was very positive.
- In general, bereavement support services are very limited and counselling is only available for those who have experienced the traumatic death of a loved one.
- However, the hospital is involved with the Hospital Friendly Hospice programme to improve standards in care and facilities for dying persons and their families.
- Across the hospital, ward sister's rooms or the Pastoral Care Office are used as relatives' rooms.
- The viewing area contains removable religious symbols and is accessible to wheelchair users.
- No multi-faith room is available.
- The chaplaincy service is involved in the provision of bereavement support.

Information leaflets

- There is a good child bereavement pack including an expression of condolence, contact details for local and national bereavement support agencies, and advice about what to do next.
- All bereavement leaflets are nationally produced, apart from one leaflet produced in-house on grieving about the death of a child.
- We were told that numbers are given for local counsellors, but no documentation was available to evidence this.
- Families are also given a leaflet on coroner's post-mortem examinations that mentions the retention of organs at post-mortem examination.
- There is no bereavement literature in relation to adults.

Areas for improved focus/action

- There are currently plans in place for a new mortuary, although the immediate priority is getting the existing mortuary to function properly. Poor hygiene, poor health and safety, poor observance of Personal Protective Equipment (PPE) and Control of Substances Hazardous to Health (COSHH) procedures were observed in the Mortuary during the audit visit.
- There is an urgent need for policies and standard operating procedures to be adopted and embedded within the work place.
- There is a need for policy revision as policies are poor and there is very poor documentation relating to the post-mortem examination practice.
- Review logging system and consider the implementation of an electronic system.

University Site Visits

Visits to academic pathology departments and medical schools played a part in the audit, to assess the nation's currently retained organs. These institutions welcomed the audit visit and were very obliging in outlining how post-mortem examination practice including the retention of organs for teaching, training and research, sits within an undergraduate and postgraduate setting.

Each institution was willing to discuss the 'pathology collection' contained within its medical school.
These collections comprise human organs, mostly of historic nature and unknown origin. In most cases it is not known whether the organ was removed surgically or at post-mortem examination. Evidence of the importance and value of these collections is the fact that many medical students and doctors in postgraduate training, especially those who specialise in pathology and surgery, find the collections provide a beneficial and invaluable archive of conditions and abnormalities.

The University of Dublin – Trinity College

Specimens currently Retained
There are **651** specimens of which **180** specimens are identifiable. Of this 180, 10 are from the 1990s, 9 from the 1980s, and 161 from the 1970s. 54 of the total are identifiable as surgical specimens.

The specimen museum at Trinity College has been in existence for many years. This audit presents data in relation to specimens held since 1970.

The museum holds a collection of specimens from both autopsy and surgical pathology. Specimens were obtained from clinically affiliated hospitals of Trinity College, Dublin, Ireland and hence the majority of specimens originated from the federated voluntary hospitals, i.e. Adelaide and Meath Hospital, Dunn's Hospital, Stephen's Hospital, Baggott Street Hospital, and more recently St James Hospital.

The specimens are kept in a purpose built facility in the teaching laboratory in the Trinity Health Science Centre at St James' Hospital, Dublin which is a secure facility used only by medical, nursing and pharmaceutical staff who attend Trinity College Dublin. The specimens are kept in purpose built locked cabinets with a designated responsible key holder to ensure that the security and dignity of the specimens is constantly maintained.

The museum is now used only infrequently for teaching, as much contemporary teaching is conducted through web based education programmes. No specimens have been added to the facility since the early 1990's and there have been no additions or subtractions to the museum collection since 2003.

There is an excellent document control system at the museum that should be commended. The identifiable specimens are all logged under specific anatomical sites and the sections of the museum where they are located, whilst records of specimens donated to the museum are all version controlled, as are records of any removals from the museum.

University College Dublin (UCD)

1st visit with University College, Dublin

Specimens currently Retained
The museum specimens were physically counted; there were **126** post-mortem examination specimens displayed in the Museum at UCD.

Many of the specimens date back to the 1950/60's (or even before) through to the 1980s. There is supporting documentation to accompany many of the specimens. Very few specimens have been added since the 1980's, the last being in 1991. During the initial visit it emerged that there were approximately some 56 boxes of specimens in remote storage. The audit team requested the return of said specimens to be counted. A return visit was planned.

2nd visit with University College, Dublin (UCD).

Specimens currently Retained
A physical count of 62 manuscript/bankers boxes was conducted by Michaela Willis and the technician in a controlled environment with appropriate PPE, as there was a possibility that some of the specimens may have leaked during transit. The count revealed 692 specimens, plus 4 boxes of bones and 2 boxes containing pictures of tissue sections. Of the 692 specimens, 3 had leaked dry and 2 of the pots contained non-human organs (one stones, another a hair ball). A small number of specimens, mainly the older ones, are in glass pots and are particularly fragile with a few specimens leaking and in need of repair or re-potting.

This visit was to count all the boxes of museum specimens that had been in remote storage since the move of the University site in early 2007. The specimens were returned to the University, where, in future some will be located in the museum and others will be kept in storage.

Each specimen had a label/number on it. Specimens in boxes for the same body system were kept together and each specimen also had a log to go with the corresponding number it had been allocated.There are records and documentation for many of the specimens held.

Some of the specimens (a small proportion) are leaking and are in need of repair or re-potting, a skill few people hold. However, the University are fortunate that their technician is trained to pot and repair and will be looking to do this in the near future.

University College Cork

Specimens currently Retained
There are **268** specimens in the teaching collection. There are **27** specimens in the previous teaching collection. There are **165** specimens in the Military collection.

Teaching Collection

The Teaching Collection is kept in a locked lecture/teaching room; the room is not only locked but also an access code is required. Students do not have the access code.

All specimens are catalogued (by discipline) and numbered and exhibited in glass pots on shelves for student to be taught from, always with supervision. When the specimens are not being used for teaching there is a blind that is pulled down in front of them. These specimens are carefully looked after and are used for regular tutorials. All specimens are anonymised, their province and date unknown, but all predate the 1970's. As far as UCC is aware nothing has been added to the collection since the 1970's, although this cannot be guaranteed.

Previous Teaching Collection

Some years ago a member of staff was tasked (an issue of space) to select the least valuable teaching specimens and put them away in a cupboard for safekeeping. There is no numbering system for these specimens nor are they catalogued. The number of specimens in this collection was ascertained by a physical count on the day of the audit visit. Again, they are all anonymised and of unknown origin.

Military Hospital Collection

This collection is housed within the same site as the 'previous teaching collection' in several cupboards. There is no numbering system for these specimens, nor are they catalogued. The number of specimens in this collection was ascertained by a physical count on the day of the audit. This collection it is believed to have come from a military hospital in Malta, where an army doctor retained them during the 1st World War who then brought the specimens back to 'The Bonds' in Ireland with him. (These specimens are currently not used).

The 'Wax Collection'

For the sake of completeness, there is a collection of wax specimens believed to be donated by a medic in 1878, created by J Beretta, one of Madame Tussauds' students. These wax specimens were exhibited in an old museum and lecture theatre in approx 1930 then were brought to the hospital lab and put in a tea chest for safe keeping. The Heritage Centre then took an interest in these specimens and have them for safekeeping. There is NO human tissue contained in these specimens, which are made out of starched linen and wax.

The Royal College of Surgeons Ireland – Dublin

Specimens currently Retained
There was a physical count of all specimens, which amounted to a total of **110** specimens and 9 bones.

The audit team visited the RCSI College collection, which is on the Royal College of Surgeons' medical schools site, Dublin. Approximately 300 undergraduate students and 50/60 graduate students pass through the medical school each year.

This building is a relatively new build and the collection was moved here when the building opened.

The teaching collection is a historical archive and all specimens are anonymised. There have been no new additions to the collections for a significant period of time. Specimens are kept locked in purpose built cupboards at all times and all students are supervised when being taught with the use of specimens. There is a list of specimens in organ groups..

It would be beneficial, organisationally, for the university to have a proper inventory of the specimens. There is also a need for the College to have a number of the specimens re-potted, although the College believe that there is nobody within the organisation sufficiently skilled to do this.

University College Galway

Department of Pathology at National University of Ireland (NUI) Galway

Specimens currently Retained
A physical count of all organs took place and this was crosschecked with the University Catalogue. There are **364** organs retained plus inflammatory lesions and **107** miscellaneous organs retained.

Organs that were removed either surgically or at post-mortem examination in the past have been retained for teaching and examination of undergraduate medical students in the Department of Pathology, Clinical Sciences Institute, NUI Galway. These organs have been collected over a period of 20 years and are deemed an invaluable teaching aid for medical students. The organs are stored in ('pots'- Organs stored in sealed Perspex containers) and in formalin within containers that can be opened ('wet specimens'). The audit team was informed that no organs have been collected, preserved and fixed and stored in perspex containers since the mid-1990's. No organs have been collected and stored as 'wet specimens', unless written consent has been obtained, since the late 1990's.

The University do not currently collect any new organs for teaching or examination purposes. All organs are anonymised and there is no information that could identify an organ as belonging to a particular individual.

A catalogue of organs retained in pots with description of their pathology is held in the Department of Pathology together with a catalogue of organs retained as 'wet specimens'.

Organs stored in sealed perspex containers -Pots

Pots are stored in the John David Kennedy Pathology museum at the Clinical Science Institute. The museum is kept locked when not in use.

The museum is used for teaching and examination purposes. It is opened prior to practical classes by pathology staff. Pots to be used for teaching in the museum are left out .The room is locked after each practical session.

Pathology examinations are also held in the museum when 'pots' are used for examination purposes.
The pots are kept in the museum at all times save the following:

Selected pots are removed from the museum during practical classes and are left in the pathology-teaching laboratory in the CSI where students who are not attending a practical class can review and study them. These are returned to the museum after each practical class.

Selected pots are used for the end-of-year exam for undergraduate medical students. They are removed for the exam and left in the pathology-teaching laboratory. The laboratory is supervised at all times and kept locked prior to the examination. Pots are returned to the museum thereafter.

Selected pots are distributed to examiners conducting viva voce examinations in pathology and, on occasion, surgery within the CSI. The pots are released and they are returned to the museum after the examination.

Students are permitted to study in the museum using pots. This occurs generally close to examination time. During this period, the room is opened every morning for the students and is locked once finished.

Organs stored as 'wet specimens'

- 'Wet specimens' are stored in three storage cupboards in the pathology-teaching laboratory.

- The organs are stored in separate and communal containers, each labelled with the organ type and/or disease process.

- Prior to a teaching sessions for medical students, the organs are removed from their containers and washed. They are left on trays in the pathology teaching laboratory to be examined by the students
- under the supervision of a consultant pathologist during the teaching session.

- After the teaching session, organs are returned to their containers and stored in the cupboard.

- Prior to an examination, the organs are once again washed and left out on trays in the pathology-teaching laboratory for the duration of the examination and returned to their presses, which are then locked.

- The organs are never left unattended during a teaching session or during an examination.

Section A Annexes

Annex 1 - Schedule of visits

Name of hospital visited	Name of person(s) visiting
Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital	Michaela Willis Nuala Harmey
Beaumont Hospital	Michaela Willis Nuala Harmey
Cavan General Hospital *(carries out post mortem examinations for Cavan and Monaghan hospitals, all post-mortem examinations carried out at Cavan and organs stored at Cavan)*	Michaela Willis
Children's University Hospital, Temple Street	Michaela Willis
Connolly Hospital	Michaela Willis Nuala Harmey
Coombe Women's Hospital	Michaela Willis
Cork University Hospital (CUH) and Cork University Maternity Hospital (CUMH)	Michaela Willis
Galway University Hospitals (GUH) University Hospital Galway and Merlin Park University Hospital	Michaela Willis
Kerry General Hospital, Tralee	Michaela Willis
Letterkenny General Hospital	Michaela Willis
Louth County Hospital, Dundalk (*all tissues samples from post mortems transported to OLOL and all post mortems from OLOL carried out at Louth County Hospital)*	Michaela Willis
Mater Misericordiae University Hospital	Michaela Willis Nuala Harmey
Mayo General Hospital	Michaela Willis Nuala Harmey
Mercy University Hospital, Cork	Michaela Willis Nuala Harmey
Mid Western Regional Hospital Dooradoyle (*carries out postmortems for the Maternity Hospital Limerick and Mid Western Regional Hospital Ennis, St. John's Hospital Limerick, Mid Western Regional Hospital Nenagh*	Michaela Willis Nuala Harmey
Mid Western Regional Hospital, Nenagh (*post mortems ceased to be carried out on premises 2003)*	Michaela Willis
Mid Western Regional Maternity Hospital Limerick *(all post mortem examinations are carried out at Doradoyle)*	Michaela Willis
Midland Regional Hospital at Mullingar (*all tissue sample and organs would be transferred to Tullamore)*	Michaela Willis
Midland Regional hospital at Portlaoise (*all tissue samples and organs would be transferred to Tullamore)*	Michaela Willis
Midland Regional Hospital at Tullamore (*all laboratory work and organs for Portloise and Mullingar stored at Tullamore)* Naas General Hospital	Michaela Willis
National Maternity Hospital Holles Street	Michaela Willis Nuala Harmey
Our Lady of Lourdes Drogheda (OLOL) (*all tissue samples and organs transported prepared and stored here for Louth County Hospital and all postmortems for OLOL done at Louth CountyHospital)*	Michaela Willis Nuala Harmey

Our Lady's Children's Hospital, Crumlin	Michaela Willis Nuala Harmey
Our Lady's Hospital Navan	Michaela Willis Nuala Harmey
Portiuncula Hospital	Michaela Willis Nuala Harmey
Rotunda Hospital	Michaela Willis Nuala Harmey
Royal College of Surgeons Ireland (RCSI)	Michaela Willis
Sligo General Hospital	Michaela Willis Nuala Harmey
St. Columcille's Hospital	Michaela Willis Nuala Harmey
St. James' Hospital	Michaela Willis Nuala Harmey
St. Vincent's University Hospital, incorporating, St. Michael's Hospital, St. Vincent's Private Hospital (*all post mortem examinations carried out at St. Vincent's)*	Michaela Willis
Trinity College	Michaela Willis
University College Dublin (UCD) Revisit	Michaela Willis
University College Cork	Michaela Willis
University College Galway (UCG)	Michaela Willis
Waterford Regional Hospital *Waterford Regional Hospital carries out post-mortem examinations on behalf of all hospitals and facilities in the* South East	Michaela Willis Nuala Harmey

Annex 2 - Hospitals not visited as part of Audit of Retained Organs

Hospitals not visited as part of Audit of Retained Organs
South Eastern Hospital Group
Wexford General Hospital
St. Luke's Hospital, Kilkenny
South Tipp.General,
Clonmel Orthopaedic Hospital, Kilcreene
Southern Hospital Group
St. Mary's Gurrenbraher
Mallow General
Bantry General
South Infirmary/Victoria Hospital
St. Finbarrs Hospital
Western Hospital Group
Roscommon County Hospital
Dublin South Hospital Group
St. Luke's
Royal Victoria Eye and Ear
Mid Western Hospital Group
Ennis General Hospital
St. Johns Hospital, Limerick
Orthopaedic Hospital Croom
Dublin North Hospital Group
Cappagh National Orthopaedic Hospital

Section B

Introduction

The main purpose of this audit was to carry out an audit of the State's currently retained organs and to ensure that arrangements were in place to enable organs no longer required for clinical purposes – or where there was evidence of inadequate consent process – to be sensitively disposed of, whether directly by the hospital or by the next of kin. Section A of this report demonstrates that this remit has been fully carried out.

However the audit team's work has inevitably involved a wider audit than just the validation of records and collections. All aspects of the process of carrying out post-mortem examinations have been investigated at each of the hospitals and Section A presents the results of that on a hospital-by-hospital basis. This section draws together a number of general conclusions from that comprehensive analysis and addresses a number of the specific generic topics covered by the audit, identifying basic principles underlying best practice; highlighting areas of good practice across the State; identifying poor and deficient practice and making specific recommendations for action to be taken. There are many complex and interwoven issues involved that it is hoped in this section to examine.

Post-mortem examinations or autopsies play an important role in the provision and improvement of medical care; they provide a means of validating or correcting diagnoses made prior to death and play a fundamental part in the improvement of care for the living. The retention of organs and tissue makes a significant contribution to this by facilitating both research and medical education and training. But these benefits cannot override the individual's autonomy and right to choice – nor the rights of the individual's family and friends to determine how the deceased's remains should be treated after death.

In relation to the latter, this report concentrates on the principle of ***consent*** rather than that of ***authorisation*** (as the Madden report recommended), as the current principle accepted across the State is the former. Until such time that there is legislative change the essential principle will remain ***consent***.

Although hospitals will be identified as exemplifying good practice this does not mean that all others are deficient.

There is a need to clarify some of the language and specific terms used in this section (and indeed throughout the report):

- Hospital staff frequently use the term '*obtaining*' consent; unfortunately this term implies that the process is largely a formality, with the outcome guaranteed. Using the term '*seeking*' consent changes the emphasis to an active process with no certainty of outcome – reflecting the reality of choice. An excellent example of this practice is to be found at Our Lady's Children's Hospital, Crumlin, where the process is described in terms of the paediatric pathologist making a '*request*' for autopsy as opposed to '*obtaining*' consent'.

- The term *organ retention* as used by many hospitals reflects a backward looking stance; therefore the term *retention of organs at post-mortem examination* will be used.

- The term *disposal of organs* carries connotations of clinical waste disposal – i.e. by incineration. As this report makes clear, such practices are unacceptable and a better term for referring to disposal by burial or cremation is '*sensitive disposal*'.

Finally as Section B makes clear, there is a range of actions now required; some by individual hospitals, to eliminate unacceptable practice and improve other practice to the standards of the best. Also required are some new facilities; extending and improving the training provided for staff; developing and promulgating standard operating procedures or templates for documents; or by introducing new legislation and regulation to ensure that where precise prescription is required (e.g. in relation to whether consent or *authorisation*

should be the basis for legitimising post-mortem examinations and the retention of organs and tissue) it can be provided and enforced.

Consent

There has been a significant shift over the past 20 or 30 years from the position where professional paternalism made the giving of consent, whether for elective surgery, for teaching and research or for the retention of organs at post-mortem examination, largely a formality, to one in which professionals are required to seek informed consent from patients or their representatives before patients' privacy and/or autonomy are necessarily and legitimately infringed as a requirement for these activities to take place. ***It is evident from the audit that this change has generally come about, and much progress has been made towards building a partnership between the public and the medical profession.***

However, seeking consent to a post-mortem examination at a very distressing time for families is a complex and difficult process for staff. There are a number of important principles, which need to be fulfilled in order to ensure that staff can proceed with confidence.

- The principle of consent is fundamental; which means that the necessary legal framework must be in place to ensure that tissue and organs are not retained without consent other than as a legal requirement of the coroner.
- The consent must be informed– which means that the necessary information must be provided in a clear, concise and acceptable manner – and it must be written consent on a proper form.
- It is of paramount importance that those who seek consent and deliver proper information are appropriately trained to do so.

On this basis the following recommendations are made for action necessary to ensure these principles are applied universally

- The person seeking consent for a post-mortem examination should always be a doctor who has had sufficient experience or training in post-mortem examination practice to be able to provide a clear description of the process and its purpose and respond informatively to any queries raised. Other professional staff could and indeed should be involved but the lead should be taken by a senior doctor (not necessarily excluding NCHDs), drawing on centrally promulgated SOPs and templates to ensure consistency of practice across the State.

- There should be a minimum standard template consent form available, which should be used by hospitals, retaining flexibility for local variations in practice. It is of paramount importance that families have the opportunity to receive full information before giving consent to the retention of organs and tissue or to refuse consent if they so choose. Part of the process of seeking consent must include the provision of information to ensure families are clear about what they are consenting to. Information about the process of a post-mortem examination must be provided. The process of seeking consent should not be hurried and supplementary information should be given to the relatives to take away and read. Information leaflets that set out the relevant information clearly and concisely should be provided nationally to support the verbal process of seeking consent.

- The regulations for seeking consent for the removal, retention, use, storage and disposal of organs and tissue for both hospital and coroners post-mortem examinations (after the coroners function has ceased) should be the same – this change should be implemented as a matter of urgency. A process of consultation in this regard is currently in under way by the Department of Health. The legislation should be specifically designed to eradicate inconsistencies across the country in relation to the process of seeking consent relating to post-mortem examinations generally.

- The need for continuous training for NCHDs in the process of seeking consent for post-mortem examination (because of the change over of staff due to rotation) has been recognised by many hospitals; even so, many NCHDs are not familiar with the procedure that they are seeking consent for. If an NCHD is seeking consent s/he should be supported by and incorporated in a proper medical team under the proper supervision of consultant, and any senior doctor who delegates this task to a junior must be comfortable that s/he is competent to carry it out.

- Every hospital MUST have consent policy with a section specifically covering the seeking of consent to post-mortem examination.

Good Practice

The hospitals that particularly stood out with regard to their practice surrounding the process of seeking consent include The Mater Misericordiae Hospital; The Children's University Hospital Temple Street; St. James' Hospital; St. Vincent's University Hospital; Our Lady's Children's Hospital, Crumlin; and the Coombe Women's Hospital. The Children's University Hospital Temple Street ensure that effective training has been undertaken by NCHDs involved in the process of seeking consent, including ensuring that they fully understand the post-mortem examination process. Our Lady's Children's Hospital, Crumlin, only the paediatric pathologist seeks consent.

'The Faculty of Pathology of the Royal College of Physicians of Ireland' issued advice about post- mortem consent and the retention of samples in February 2000.[7] This impressive document included specific guidelines for seeking consent, recognising (well before most other authorities) parental sensitivities surrounding the retention of organs at post-mortem examination.[26] The advice in this document has clearly been taken on board by hospitals such as The Children's University Hospital, Temple Street, Our Lady's Children's Hospital, Crumlin, St. James Hospitals, St. Vincent's University Hospital, The Mater Misericordiae Hospital and Coombe Women's Hospital.

In 2002 the Eastern Regional Health Authority produced a model consent form for hospitals to use and ***it is evident that a significant number of hospitals took this form on board and utilised it as a minimum standard.***[9]

Other hospitals, albeit a minority, have made no attempt to produce a satisfactory consent form. The hospitals that were found to operate poor or unacceptable practices in relation to consent forms should remedy this immediately.

This practice should be audited six months after the publication of this report to ensure that it has been updated.

Policy and Practice - Retention of Organs and Management of Post-Mortem examination and Mortuary facilities

All hospitals carrying out post-mortem examinations and all facilities involved in the retention and storage of human organs should have clearly documented management procedures in place.

Such policies should:

- clearly set out the fundamental principles on which practice is to be based, emphasising the need for dignity and consideration,
- set out clear, step-by-step procedures (standard operating procedures –SOPs) for the full range of relevant issues and activities, such as consent, communication with families, storage and transport arrangements, arrangements for sensitive disposal, record keeping, liaison with coroners and bereavement services, health and safety, incident control and so on. (A more comprehensive although not exhaustive list is at Annex 3),
- set out clearly lines of accountability and managerial responsibility,
- be fully version controlled and regularly reviewed,
- be evidence-based so far as possible and include a regularly reviewed risk assessment statement,
- be fully embedded within the management of the institution, including specific training where appropriate,
- be jointly prepared and owned by all the institutions involved wherever a number of hospitals jointly provide services,
- be widely available and familiar to all staff involved, training logs must be kept,
- be publicly available on request,
- be subject to periodic audit in relation to compliance.

Where policies and procedures are in place which conform to these principles, they are generally very good indeed – as can be seen from the analysis in Part A. In particular, those at the Coombe Women's Hospital; The Children's University Hospital, Temple Street; The Mater Misericordiae Hospital and St. James' Hospital exemplify the great majority of these principles to a very high standard. Good policies can also be observed at Cavan Hospital, Cork University and Cork University Maternity Services; and Portiuncula Hospital. However there are a number of areas which would benefit from specific action, which would in turn help to ensure that families involved with the retention of organs following post-mortem examination – both in respect of organs retained in the past and those who are involved in the future – receive the best possible service from the State's hospitals.

- The current operation of some mortuary services in the State is excellent. However, some policy and standard operating procedures are either not in place or not up to date with contemporary practice. All should be brought up to the standards of the best without delay – Section A clearly identifies those hospitals that need to implement improvements here. Their progress in doing so should be centrally monitored by a regular audit.

- It is desirable that there be shared laboratory and mortuary packages, with all documents, logs and controls to all procedures controlled by the laboratory, to ensure effective quality and safe working practices are in place. The laboratory would hold ultimate responsibility for the controls process, the quality of records, and clinical material with appropriate procedures underpinning it and a staff-training log. The most commonly observed software suite used in Ireland is Q-pulse.

- There was very little evidence in the documentation accompanying the audit returns to indicate that a mortuary facility risk assessment had been carried out. In fact only in 2 instances was the team provided with a risk assessment. Given the many risks and hazards present in the mortuary this deficit needs to be addressed as swiftly as possible. Once again central guidance including a template and a training package would greatly assist the consistent implementation of this recommendation.

Previous Guidance

The Eastern Regional Heath Authority produced guidance in December 2002 setting out *'protocol/guidelines for hospitals and other relevant agencies in providing a quality response to families in relation to non-coroners post-mortem examination practice*[9]. The primary purpose of this document was to standardise practice between and among hospitals. There was a significant emphasis on consent and ensuring families had enough information to make an informed decision.

- It included a sample consent form and set out the information process relating to organs being retained at post-mortem examination,
- it also covered communication with families; consent options in relation to carrying out a post-mortem examination and the retention of an organ/s at post-mortem examination; communicating results to families; and choices for families in relation to organs disposal,
- the storage of organs following completion of post mortem, record management. It lays out what discussion should take place, the disposal of organs.

This was a very good document at the time and much of it is still relevant. However there is a need for revised and updated guidance on many issues. Having said that, if all hospitals had carried out practice to this standard this would have been an excellent achievement.

The area where there is significant deviation is document and record management. It also quite disconcerting that a model consent form was provided yet a number of hospitals chose to adopt a less informative consent form.

There was further guidance produced, again by the Eastern Regional Health Authority, a *'protocol/guideline for hospitals and other relevant agencies in providing a quality response to families in relation to coroners post mortem practices'*.[27] Once again for its time this guidance was very good. It covered circumstances where there was an obligation to notify the coroner of a death; communication with families; and organ/s storage following completion of the coroner's post-mortem examination. These two documents set out to standardise practice between and among hospitals; they included a recommendation for hospitals to review their policies and guidelines in the area of post-mortem examination practice on a regular basis. There was also a significant emphasis on the need for adequate consultation with grieving relatives. There is a need for a review of this guidance but it was a very good starting point to which some hospitals do not yet conform, especially with regard to disposal options for retained organs, although at least half of the State's hospitals do comply with it.

This practice should be audited six months after the publication of this report to ensure that it has been updated.

Records management

Effective records management is of vital importance in ensuring an acceptable outcome from all aspects of the post-mortem examination process – from ensuring that the right body is examined, through ensuring that toxicology and other test results are assigned to the right case, all the way to ensuring that returned or buried organs are correctly identified and associated with the correct deceased person. The absence of effective records management leads to disrespect for the dead and mistakes and time wasted for the living.

Record keeping is in some places of a very high standard; in a few hospitals this is further reinforced because there are electronic systems linking with the laboratory system. In others documentation is of a good standard but the mode of recording is archaic. In the remainder, record keeping and documentation is poor. Handwritten logs must be completed in neat and legible handwriting – not in illegible scrawl and with the use of incomprehensible abbreviations. An audit trail is essential to ensure that record documentation surrounding post-mortem examination practice provides an accurate basis for the activities involved.

The following action is essential to ensure that the systems of record documentation in all hospitals in the State are fit for purpose.

- All laboratories in the State have the use of IT, and all their laboratory logs are electronic. It would be hugely beneficial to bring the mortuaries into line with laboratory systems. There are a small number of sites that already do this, but most are reliant upon the hardback book method. There should ideally be logs within one electronic database and not a plethora of individual hard back books; while the latter may be fine as supplementary or back-up systems they are hard to search; cannot be linked with other databases; and do not carry sufficient information. An outline of the minimum data set is at Annex 4. A basic procedure guide setting out some fundamental principles of record keeping is at Annex 5. Consideration should be given to a national programme to modernise mortuary record keeping systems – including providing funding and training to ensure that new systems are introduced quickly and used effectively.

- There are a number of cases of particular difficulty in hospitals where there are split sites and practice is carried out at different geographical locations; i.e. the post-mortem examination is carried out at one site and the histology is prepared at another. This is not the case with all shared services and in some hospitals this works well, even though most would be more effective if IT-based and linked to local laboratory systems. Practice at all such split sites needs to be brought up to the standards of the best.

- In some cases there is no management or governance of the procedures that take place and no effective monitoring mechanisms. In some places the facility where a sample is removed provides no log, account or tracking of the specimens removed, this would also apply to organs removed in 'State cases'. This is unacceptable and effective systems must be introduced at these facilities as a matter of urgency.

Examples of good practice include:

- One hospital group – The **Midland Regional Hospital** group covers a large geographical spread and 3 sites (Tullamore, Portlaoise and Mullingar Hospitals). All 3 sites perform post-mortem examinations but the histology from each is referred back to Tullamore. Each site has its own unique bar code number and a log at each hospital, each hospitals bar coding system has a colour unique to that hospital bar code as a further double check that no samples are mixed up. This system, albeit still paper based, is one that gave confidence.
- Organ logs, with full tracking, from removal right through to disposal were excellent in some hospitals and well detailed. Hospitals with such excellent tracking included the St. James' Hospital; St. Vincent's University Hospital; The Children's University Hospital, Temple Street having

electronic logs and Our Lady's Children's Hospital, Crumlin having a duel process and Portiuncula Hospital a hard back book system.

It is essential to keep full, accurate contemporaneous note of the procedure and all that relates to it. There is no way of knowing what happens during a procedure without proper records. Accurate patient records and related logs are essential, not optional. Apart from providing a sound basis for effective post-mortem examinations and considerate return or disposal of any retained organs, effective records are needed in the event of a complaint or litigation. For the safe and skilled practitioner proper document keeping is an integral part of patient (living or deceased) care. There should be benchmarking standards or measures and clinical appraisal with regard to record keeping and maintaining logs. It was very evident that there is very little training for staff in this regard; therefore it is hard to expect them to fulfil this function appropriately.

This practice should be audited six months after the publication of this report to ensure that it has been updated.

Communication with families

The consent process for hospital post-mortem examinations provides the framework within which the basis for effective communication between staff and families may be established – or not. There are fewer opportunities to establish a good relationship in relation to coroner's post-mortem examinations where the question of consent may well not arise. In any case, effective communication is founded upon a number of basic principles or requirements.

- Mutual respect and respect for the dignity of the deceased person
- A single individual responsible for establishing and maintaining the dialogue with a particular family
- Clarity and confidence on the part of the member of staff involved, resulting from effective training
- Time and patience to explain what may seem a complex process at a very difficult time when comprehension may be undermined by grief
- Providing truthful and comprehensive information as early as possible within the process – not as an afterthought. For example on occasions some hospitals retain the pituitary gland (a small organ that intact could be embedded in a wax block and kept as part of the medical record) in some cases people are still not being informed that this tiny organ is being retained and secondly not being offered its return for disposal.
- Time to process and reflect on the information that has been delivered (cool off period) and the chance for a change of mind, should that happen.

Good practice

In some hospitals the standard of communication with bereaved families is excellent - for example St. James Hospital and The Children's University Hospital, Temple Street both have an exceptionally high standard and should be considered exemplar sites in this regard. Some other hospitals also have very good practice such as Beaumont Hospital.

Action needed:

- To ensure that standards of communication are raised to the levels of the best (see above) a number of actions are needed.

- Effective written support for the communication process should be provided – not just an information leaflet for the families but briefing notes to assist those members of staff responsible for communicating with next of kin. An outline of the content of such advice is set out in Annex 6.

- Effective communication is almost always associated with well-directed training provided for the staff involved. All those hospitals, which do not already provide training – including role-playing – in this area, should consider doing so as a matter of urgency.

- There is in particular a lack of clarity about what information should be provided to families at the time of a coroner's post-mortem examination with regard to the wishes of the next of kin once the coroners function has ceased. There is also a lack of consistency around who should take responsibility for communicating with families about the need and implications of a coroner's post-mortem examination. This in turn reflects the need for more effective liaison and mutual understanding between hospital staff and coroners, which should be addressed as a matter of urgency.

- It is clear that ALL hospitals which observe good practice in this difficult area have definitive rules which require that certain deaths must be reported to the coroner, reflecting the duty for those with responsibility for the patient's care to notify the coroner of a death that falls within the category of death reportable to the coroner. All staff should be familiar with what these are and they should be detailed in the hospital's policy.

- There should be a minimum standard for the information given to the next of kin; as advocated by the Coroners Bill 2007.[28]

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This practice should be audited six months after the publication of this report to ensure that it has been updated.

Organ disposal arrangements

The audit focused on the arrangements for the sensitive disposal of organs retained following a post-mortem examination in two distinct parts:

- Organs from pre 2000 disposed of post 2000
- Post 2000 and current sensitive disposal of organs following either a hospital post-mortem examination or a post-mortem examination ordered by the coroner.

Organs from pre 2000 disposed of post 2000

Following a meeting held at the Health Board Offices, Tullamore on March 24th 2004, by the Eastern Regional Health Authority' including representatives from the South Western Area Health Board; the Western Health Board; the South Eastern Health Board; the Midlands Health Board; the Southern Health Board; the Mid Western Health Board; the Midlands Health Board; and the North Eastern Health Board; and from The Children's University Hospital, Temple Street; Our Lady's Children's Hospital, Crumlin; Rotunda Hospital; St. Vincent's University Hospital; the National Maternity Hospital, Holles Street; the Coombe Women's Hospital and Beaumont Hospital, a way forward was generally agreed to enable sensitive disposal of accumulated retained organs held by the hospitals involved. This involved 2 separate elements:

- Agreement on a set of guidelines which had been drawn up earlier to determine the procedure, documentation and related matters to enable sensitive disposal of accumulated retained organs.
- Agreement that as every effort had been made to inform the public about the practice of organ retention and to offer families the opportunity to come forward, it was 'now appropriate to take decisions in relation to retained organs' and to proceed to the sensitive burial of unclaimed organs (organs that no contact to the hospital had been made) (the preferred option was burial on the grounds, that the organs could be clearly identified and retrieved if required at a future date).[2]

On the strength of this discussion the majority of the hospitals then proceeded to bury organs in hospital plots with a record of the burial, to provide information should any future enquiries be made. This was a completely acceptable and dignified decision to have been made. St. James Hospital cremated and then buried the organs.

However, following this meeting a number of the hospitals who had been represented chose not to bury the organs in accordance with this decision, on the basis that there had been no definitive guidance with regard to disposal of organs. The three hospitals were:

- The National Maternity Hospital, Holles Street
- Our Lady's Children's Hospital, Crumlin
- Rotunda Hospital

The problems flowing from this were two-fold. To begin with, although the guidance was for its time excellent, it is evident from the audit that while a few hospitals have managed full implementation, many have not, especially in relation to documentation and providing an audit trail for the mortuary. Secondly, there were three hospitals that did not take action with regard to the logging and documenting and disposal of pre 2000 organs until further definitive guidance after the meeting in March 2004. This would have provided respect and without preventing later enquiries being answered.

It is important that the sensitive disposal of the outstanding organs should take place in accordance with the good practice guidance; if necessary legal powers to require this to be done should be incorporated in the forthcoming legislation.

Current sensitive disposal of organs following a hospital post-mortem examination

- Arrangements for the sensitive disposal of organs after a hospital post-mortem examination are generally very good.
- Next of kin are normally given options with regard to their wishes to sensitive disposal of organs. The options are:
    a) Return to family for private arrangements,
    b) Hospital burial in hospital plot,
    c) Cremation,
    d) The hospital being given consent to retain for research/education purposes

However there is evidence in Section A that in a small number of cases disposal appears to be by incineration. It should be emphasised that such a method of disposal is disrespectful and totally unacceptable. ***This practice should cease immediately and the HSE should seek confirmation of this from the relevant Chief Executives, endorsed by their Chairs, within three months of the publication of this Report.***

- Disposal should always be recorded in the organ register/log. Again there is evidence from the audit that some hospitals are failing to carry this out effectively. It is important that this deficit be remedied as quickly as possible – again achievement of this should be monitored centrally.

Current disposal of organs following a coroner's post-mortem examination

Good practice requires that:

- The family be informed of the retention of organs at post-mortem examination by the Coroner's office and given the information from the Coroner's office that is sent out to all cases. ***In practice the process is often very different to this.***
- There needs to be an identified individual with a clearly defined role or responsibility who provides this information to the next of kin. Again ***this is not the way the process happens in many hospitals.***
- There should be consistency in the information provided and the forms people are required to sign. In practice there are a variety of information sheets setting out the options and describing the benefits of retention. Some hospitals provide acknowledgement forms to sign; whilst some families have disposal forms from the coroners' office direct and others have disposal option forms or find the options included on the acknowledgement forms.
- Training should be provided to ensure that staff provide good information about the process and any options available to the next of kin. Evidence suggests that no training is given to the majority of hospital staff with regard to providing information in coroner's cases and often the quality of service delivered is not the same as if a hospital post-mortem was taking place.

Some of these deficiencies could appropriately be remedied within the proposed legislation; others require effective action by Coroners and the Health Service Executive to ensure they are tackled constructively.

Other issues:

Unidentifiable fetuses

- There are a small number of unidentifiable fetuses and identifiable fetuses in hospitals; consideration should be given, with immediate effect, by the HSE, to the final resting place for these babies.
- It is recommended that guidance on the sensitive and appropriate burial of these babies is issued, again with immediate effect.

The cremation of organs

There are a number of hospitals that have been informing families that there is ash from a cremated organ as the crematorium informed them that this was the case. Although there is some controversy about this, there

is no evidence that ash remaining after the cremation of human organs – in the absence of any bones – is from the cremated organ. The only ash that would be available is that from the casket. Unless evidence emerges to the contrary, those hospitals should ensure correct information regarding ashes is given to families.

Action required

As has already been mentioned, there is evidence that a small number of hospitals had disposed of human organs by incineration, contrary to guidance.[9] [27] *This is addressed under individual hospital sections.* ***All other practices covered in this section should be audited six months after the publication of this report to ensure that they have been updated.***

Storage and Transportation of Organs and Specimens to other hospitals

The storage of organs across the State is mostly acceptable, although there were some examples of unacceptable practices, including organs in containers kept on surfaces and floors rather than locked away in cupboards. These are noted in Section A **and the hospitals concerned should be audited in six months time to ensure that practice has been updated.**

Following the removal of tissue and organs at post-mortem examination that need to be transferred to another hospital, good practice requires that:

- Specimens must be packed and referred to the laboratory with identification number and/or medical records number in a specimen pot and placed in a biohazard bag prior to removal from the mortuary- with the initials of the technician/prosector then logged on the laboratory system - and then sent by appropriate transport to the referring hospital. These procedures were not in evidence in a number of hospitals where the standard of packing of specimens was extremely poor.
- In relation to transportation, there was evidence of good practice in some places - for example at Portlaoise and Navan Hospitals. However there were a number of establishments where transportation arrangements are unacceptable.

Action is therefore required to remedy these deficiencies, both nationally and specifically by those hospitals whose practice is unacceptable. In particular:

- Irrespective of where the histology is processed, organs and tissues removed in a post-mortem examination room must always be recorded in a log on site to provide a complete audit trail.

- There must be a policy or standard operating procedure (SOP) for the transportation of specimens including classification, packing, labelling and documentation.

Mortuary Services

The current operation of many mortuary services in the State is excellent; yet some others are running less optimally, with inexperienced or unqualified staff with no professional education programme in place; an excessive workload; some policy and SOPs not being in place or up to date with contemporary practice; inadequate equipment and poor organisation:

- However, in ALL hospitals post-mortem examinations are performed and completed in a timely fashion.
- Some mortuaries that have excellent facilities are at St. James' Hospital (exemplary standard); Cork University Hospital; Tullamore Hospital; Mid Western Regional Hospital, Doradoyle; AMNCH; and St. Vincent's University Hospital.
- Others have good facilities but are compact - for example, those at the Children's University Hospital, Temple Street and the Coombe Women's Hospital.
- A number of mortuaries are substandard; it is understood that there is a capital project to modernise such facilities, in some cases centralisation of services should be considered. Standards are well set out in *'Facilities for mortuary and post-mortem room services'*.[29]
- Many of the current facilities are unsuitable for high-risk post-mortems/infectious cases, although there are a number of facilities that have excellent isolation suites (such as those at St. James Hospital, with three individual suites - although one is closed due to a flooring problem – and the Mid Western Regional Hospital, Doradoyle, which has an isolation suite that is not in use).
- Security of a mortuary is very important and there must be restricted access. This is again varied - some areas are excellent: with combination locks; limited swipe card access; and security cameras. In others the security is poor. There should be a risk assessment in all mortuaries with regard to security.
- Signposting for the mortuary is very good throughout the State.
- In relation to body storage, many of the refrigerators across the State are quite old and in need of replacement.
- There is a necessity for all hospitals that have neonatal deaths to have separate refrigeration for these babies. Many of these babies are laid out with the family much of the time whilst they remain in the hospital but there are times when cold storage is required and it is only dignified to have this provision - a domestic fridge is not acceptable.
- Generally viewing facilities for relatives were not to a high standard and with small amendments to environment could be much improved. Exceptional standards were found at St. Vincent's University Hospitals and the Children's University Hospital, Temple Street.
- Mortuaries and post-mortem examination facilities are of a variable standard throughout Ireland. However whatever the physical state of the mortuary there are policies, SOPs and documentation that need to be adhered to.
- There are variable standards in relation to observance of appropriate quality standards including risks associated with the mortuary and the use of personal protective equipment (PPE). There were some hospitals that paid great attention to PPE but others failed to observe its proper use, including the use of gloves, aprons, long sleeved gowns, scrubs, visors, appropriate footwear and caps. Some of the facilities that exhibited good practice were AMNCH, Cork University Hospitals (CUH & CUMH), Portlaoise Hospital, Tullamore Hospital, The Mater Misericordiae Hospital, St. James' Hospital, The Coombe Woman's Hospital and the Children's University Hospital, Temple Street.
- Mortuaries should observe the highest standards when dealing with infectious cases and should follow suitable precautions. E.g. the body should for health and safety reasons be placed in a body bag and labelled 'infectious'; all staff who work within the mortuary must be informed that the case is infectious and must follow the appropriate standard operating procedures for such cases.
- It was also evident that there is a need for health and safety and substance hazards training and awareness of Control of Substances Hazardous to Health (COSHH) measures and procedures.
- There was also a variance of practice with regard to the adherence to 'clean' and 'dirty' areas in mortuaries.

- Pathologists and technicians should have an office for all the documentation related to the deceased.
- There must be appropriate changing and shower facilities for staff.
- There is a need for IT equipment and IT training in many mortuaries.
- There should also be access to counselling/ supervision for all staff who work with the deceased on a regular basis.

Practices in this area should be audited six months after the publication of this report to ensure that they have been updated.

Training and Education

The vast majority of hospitals carry out post-mortem examinations on behalf of the coroner and hospital post-mortem examinations. The ethos across the State is currently very strong in relation to care of the deceased and care for the deceased's relatives. However there is a need for all relevant staff that come into contact with the bereaved to receive training to strengthen services with regard to:

- Caring for the bereaved when viewing a loved one
- Seeking consent to a post-mortem examination from relatives
- Informing a relative that a coroner's post-mortem is to take place
- Bereavement, trauma and psychological distress and the role of pastoral care for the next of kin of deceased patients
- Managing emergencies
- Handling complaints and complaints resolution
- Background information for emergency staff and ward staff regarding coroner's post-mortem examinations
- Dignity and respect
- Communication skills
- IT skills
- Dealing with the death of a child or baby.

Training and Education for Anatomical Pathology Technicians (APT) and/or Mortuary Assistants (MA)

- The role of a technician is not easy; s/he is a skilled professional whose job has many different facets including assisting during a post-mortem examination, meeting bereaved people; completing documentation; working with funeral directors; unsociable hours; and dealing with many traumatic deaths.
- This position should not be undervalued; it should have the appropriate pay scale and job description set by the Health Service Employers Agency,[30] and hospitals should not seek to avoid paying the proper rate by using healthcare assistant or porter's rates as is evident practice in many cases. Out of hours payments should be reviewed.
- This role however has distinct lack of standards and training across the State, being filled by well-trained staff in some places and unqualified staff in others. There needs to be some creativity in the role to provide the nation with a supply of qualified staff and opportunities for career progression to management level. There is virtually no evidence of continuing professional education (CPE).
- A CPE package for mortuary staff should be developed and introduced nationally. There should be a competency-based assessment for all staff dealing with the bereaved; this should be primarily APT/MA-based and then a training programme should be delivered to address any identified needs.
- Currently staff CPE is virtually non-existent and there is no staff development, staff personal portfolios or career development schemes other than the occasional training schedules that indicate who has been trained to understand specific policies and procedures.
- It was also observed this is a very isolated profession, especially for those undertaking lone working; there is a need for networking, mentoring or progression supervision. There is virtually no pastoral care or supervision linked to training.
- There is also a distinct lack of training for those working in general hospitals on the skills and sensitivities surrounding a child's death.
- There should be an Ireland-based training programme for anatomical pathology technicians.
- All those wishing to train currently have to attend courses in the UK. There are no standards or career structure or career progression; many 'morticians' are porters or healthcare assistants.
- A high percentage (see below) of mortuary staff are not qualified. Training is a long-term investment that needs to be made; not only are many staff untrained but a high proportion of the technicians/morticians that are in post are approaching retirement. There needs to be some rapid succession planning alongside national training for the relevant certificates and diplomas. There is great need for 'bank staff' or staff that can cover holiday, sickness and leave; providing this group

would provide an ideal opportunity to train an extra cohort of technicians. Also, those protected by a 'grandfather' clause should undergo some kind of competency assessment and be required to undertake continuing professional education.

- There should be a 'declaration of interests' register for all those working within mortuary services, to ensure openness and transparency as there seem to be a number of staff who have other interests that may or may not impinge upon hospital practice. In cases where there is an identified interest and other work is undertaken on hospital premises, this needs to be fully documented for the protection of all parties. (For example, members of staff who hold public office; or hospital employees who perform embalming services on hospital premises in their own time and have a separate income from it). Provided that staff are trained and there is organisational agreement, there would be no problem. There are a number of sites where this practice takes place and it should be formalised or the practice should cease. Declarations that are not currently on a register should be obtained retrospectively and should in future form part of the recruitment process.
- The following figures demonstrate the extent of the qualifications and training of anatomical pathology technicians in Ireland at the time of the audit team visits; the figures indicates the numbers of staff who work in mortuaries across the State, are in each category:

  Trainee/ health care assistant - 13
  Certificate trained APT - 13
  Diploma trained APT - 21
  Agency APT - 2
  Porter status - 9 (these individuals perform the functions of mortuary technician/anatomical pathology technicians.)

- It is also commonly found that there are 2 qualified technicians in one institution and no trained staff in another; qualified staff are mostly urban-centric.
- Technicians should be able to demonstrate their competence with personal portfolios that include records of attendance at conferences and seminars; talks attended; continuing professional education, annual reviews. Records of staff induction and orientation courses; relevant educational and professional qualifications; annual training with regard to policies and procedures; and departmental training (occupational heath issues, fire, manual handling, vaccinations). There is an induction course run at AMNCH for APT's where a certificate is provided; however it is not a recognised or accredited qualification.
- It was also observed that there is a need for training with regard to Health and Safety issues including Control of Substances Hazardous to Health (COSHH), the use of personal protective equipment (PPE) and general health and safety issues.

The audit team observed practice in several hospitals that was not appropriate:

- Lack of dignity and respect for the bodies of the deceased;
- Incomplete stitching of bodies before embalming/transportation (see also section on embalming);
- Lack of observance of standards appropriate to a mortuary.

ALL staff working in mortuaries should undertake CPE with regard to appropriate contemporary practice for the above.

- Staffing structure and training must be improved in mortuaries across the State; mortuaries should be subject to spot checks to drive up standards over the next six months at which point a further audit should be carried out. All the audit team's visits were prepared for and still some bad practice was exhibited.
- Development days should commence with immediate effect. These are essential to provide networking, as many staff are lone workers. The days should include reconstruction of bodies (especially those of children and babies in hospitals that are not familiar with such practice); dignity and respect; COSHH and PPE; dealing with paediatric cases; consent; communicating with the bereaved family; IT skills and documentation and record keeping.

Development of Bereavement Services

There is a need to define the principles that will underpin bereavement services and the professional practice that supports the delivery of services surrounding the care of the deceased person and the deceased person's relatives.

There are currently particularly significant services provided for the parents of a child who dies. These arrangements should be broadened to embrace all relatives of deceased patients whatever the circumstances surrounding the death. It is also evident that currently there is a far greater support network for the parents of a child who dies of cancer or in ICU, mainly due to the intensity of the working relationship. This should be built on to improve services for others not currently so well provided for. There is evidence that where a child's body is transferred from another hospital for a post-mortem examination that the services that their family receive are relatively poor as there is no support from within the original referring hospital and no structured outreach support.

There are a number of principles that should be enshrined within any bereavement standards:

1. Respect and dignity for the deceased.
2. Equity and equality of service provision.
3. Information, communication and choice underpinned by collaboration of professionals and departments and service providers.
4. The provision of a quality service set in appropriate environment with appropriate facilities.
5. All professionals should be trained to a standard, which is appropriate for them to carry the position that they hold, underpinned by continual learning.

Bereavement, grieving and loss are processes, which everyone deals with in their own way and every way is legitimate provided it does not impinge detrimentally on others. This is an ethos that should be adopted and understood by those who work with the bereaved.

There is a need for evidence-based practice where review and audit is an essential component. All issues such as consent to post-mortem examination, the retention of organs and all the other issues raised in this report are integral to the provision of a bereavement service and the policies and SOPs that underpin being embedded within the organisation is important.

There is also a need for management support and for bereavement services to be embedded within a governance framework. This is particularly important for the staff who deliver the service. There was some evidence of good practice with the establishment of bereavement committees within hospitals, to provide a forum, a coming together for the staff and a stimulus for improvement.

Awareness of different cultures, religions and race

There was some evidence of a failure to understand and reflect the wide range of needs of an increasingly diverse ethnic community within the provision of bereavement services. Many places demonstrated good practice in this respect – as can be seen from Section A of this Report – but there were some whose provision or attitudes left something to be desired.

It is vital that bereavement services are able to respond to the diverse needs given the central role which death plays in most religious belief systems – failure to provide for religious needs or to understand the significance of the retention of organs at post-mortem for certain religious groups could greatly intensify the grief being experienced. Recognition of diverse ethnic requirements also extends to those with differing lifestyles – such as travelling families - not just different religious beliefs of those from other countries.

The response to death should be framed around the cultural, racial and/or religious contexts of the deceased's belief system. Ireland, like most countries, experiences the richness of contemporary society, which encompasses many cultures and religions. But many services reflect the dominance of one religious and social ethos in the extent to which multi-faith facilities are provided less effectively than those provided for the majority. There were some striking exceptions to this criticism – such as the service provided by The Children's University Hospital, Temple Street.

Most hospitals have a last offices policy; however, there is a need for continuing education to ensure that the care given to the deceased patient and the grieving relatives responds fully to the cultural and/or religious beliefs and needs at this time.

Embalming Practice and Embalming Services

National practice is extremely varied; very few establishments visited have a level of 'embalming governance'. Although there are a small number of hospitals where embalming does not take place, the majority would regularly have funeral directors' embalmers performing procedures on the hospital premises. In principle there is no objection to embalming (an invasive procedure performed on a body to preserve it after death, with the consent of the family) taking place in hospital facilities. In practice, there are a number of issues:

(i) This consent is frequently not *informed*.
(ii) Personnel from outside the hospital are performing these procedures on hospital premises, in many cases without supervision or any checks on their qualifications or on their indemnity or public liability insurance.
(iii) In the vast majority of cases there is no Service Level Agreement (SLA) or Standard Operating Procedure or any obligation for the external embalmers to conform to any hospital standards relating to dignity and respect when working with a deceased patient; observance of proper health and safety procedures including PPE; or proper procedures relating to manual handling, disposal of fluids and incident reporting.

Having said that, St. Vincent's University Hospital, Navan Hospital and the AMNCH have contracts and the Children's University Hospital, Temple Street always supervise embalmers and check their qualifications.

Arising from the above, it would appear that in that vast majority of cases:

- there is little internal governance
- the current level and standard of practice in most cases is not acceptable, in others practice is unsupervised.

It is also the case that in some hospitals the Anatomical Pathology Technician/Mortuary Technician (again not always qualified) may also perform embalming on the premises. There are issues about the individual's qualifications; about whether the individual is working for the hospital or for the family; about payment; and about the legitimacy of the activity and whether the hospital is aware that the activity is taking place. Some of the practices may be ethically, financially and legally questionable. Some bodies are not of deceased patients from within the hospital or those 'brought in dead' but have simply been brought into the mortuary to be embalmed.

There is also concern that bodies are being moved from one hospital to another facility after post-mortem examination for embalming at another facility (sometimes a hospital but other times a funeral home). On these occasions a body may leave the hospital and be transported in an unsatisfactory and undignified state. Or in some mortuaries the bodies are left out unstitched after a post-mortem examination until embalming is completed. These practices are abhorrent and undignified and should cease with immediate effect.

The practice of embalming - still prevalent in hospital mortuaries in Ireland, is not regulated or even overseen in any way. In some establishments dignity and respect is not a priority and there are some practices that are inappropriate and improper; this must be investigated further, some practices stopped and other practices improved.

Action needed

There is an immediate need for Service Level Agreements to be put in place with external operators who use hospital premises to ensure that quality, safety and performance levels are clearly defined. The minimum requirements are that:

- All procedures should be supervised if on hospital premises
- There must be production of qualifications and professional indemnity insurance
- External operators must read and confirm that they understand the standard for operation and safety procedures and confidentiality for working within the hospital premises

- Under no circumstances should untrained staff and unqualified staff be performing embalming within hospitals
- The hospital should periodically monitor the performance of the service provider on hospital premises and this should be kept under continuous review
- Embalming should be done only by those who are qualified to embalm and if conducted on hospital premises only under a SLA and supervision and provision of indemnity insurance.

These are issues of significant importance that the HSE were alerted to and are being actioned.

Specialist units

The Beaumont Hospital also includes specialist units such as the Irish Brain Research Foundation (IBRF) and the "brain bank"; the Creutzfeldt-Jakob Disease (CJD) Surveillance Unit- National Referral Centre; and the eye bank situated in Pelican House.

The Irish Brain Research Foundation

The IBRF has ceased activity, although there are still signs in the hospital referring to it, which should be removed urgently.

Brain Bank

The 'brain bank' term is used loosely as the brain bank has neither the funding nor the facilities to perform the role of a proper bank.

There should be brain bank facilities and funding for a brain bank and there is currently a good business case to support this.

There is an urgent need for clarity surrounding the consent form and written information for the public about the status of the "brain bank" for prospective donors and referrals. While in principle the collection of brains with consent is wholly appropriate, the information and infrastructure for the delivery of this information needs urgently revisiting. There should be a policy put in place at all referral hospitals. The governance arrangements surrounding the "brain bank" need strengthening.

Referral of brains/ organs to specialist centres for examinations

Currently the system for recording and tracking referred brains and other organs is of a variable standard and in many cases not a high standard. Not all specimens are recorded or returned, as they should be. There needs to a proper system in place underpinned by proper policies and SOPs with regard to brains referred to the hospital and this should be disseminated to all referring hospitals making their responsibilities clear. Beaumont Hospital (one of the largest sites receiving referred organs) should not accept brains for referral if these processes are not followed by other hospitals.

CJD Surveillance Unit- National Referral Centre

Beaumont Hospital is the single designated hospital to deal with all CJD cases and arrangements are made for all other hospitals in the state to refer all suspected CJD cases to the Neuropathologists in Beaumont to perform the post-mortem examinations required to confirm the cause of death. There are no specific policies and SOPs with regard to CJD cases. These should be drawn up and put in place with immediate effect. The post-mortem examination suite is not fit for purpose as a national surveillance centre for CJD; equally the isolation room is not up to specification for an isolation room and was used for storage. This facility should be upgraded as soon as possible or the post-mortem examinations should be performed at one of Dublin's hospitals that do have proper facilities. There is also no evidence of a liaison person to work with families with regard to CJD or suspected CJD cases. The Health Service Executive should consider and support this as a matter of urgency. It is understood that Beaumont Hospital have taken action on the above issues.

Eye Bank

Since January 2004 the eye bank situated in Pelican House (headquarters of the blood transfusion service) has no longer accepted donations of corneas as Ireland has the highest rate of variant CJD in the world next to the UK. Corneas used in Ireland now come from the USA.

University Collections

Section A reports on the results of the audit visits to the University/Medical Colleges to inspect their teaching collections of human organs and tissue. The importance and value of these collections is demonstrated by the fact that many medical students and doctors in postgraduate training, especially those who specialise in pathology and surgery, find the collections provide a beneficial and invaluable archive of conditions and abnormalities. Although as the reports in Section A make clear, the arrangements made for the management of these collections are broadly satisfactory, there are a number of issues identified which give rise to the following recommendations:

(i) All universities should have a full inventory of currently retained organs and should keep comprehensive records of additions and of sensitive disposal

(ii) There should be a national database of specimens

(iii) Organs that are stored should be offered on loan for uses at other universities if they could use them, rather than just keeping such organs in storage

(iv) There should be one full time Anatomical Pathology Technician responsible for potting and other specialised services in relation to these collections, who would provide services to all the University/College collections as necessary.

(v) Serious consideration should be give to the future of the use of organs as an aid to contemporary teaching, as much is web based today. There should be consideration of whether all specimens should be plastinated. This would make the specimens much more versatile and accessible for teaching purposes. It would also remove the need for the additional technician called for in recommendation (iv) above.

Implementation Plan

This audit has identified a broad sweep of actions needed not only to ensure that organs and tissue removed at post-mortem examination is respectfully and efficiently managed and ultimately disposed of once it is no longer needed, but also action to ensure that mortuary and bereavement services can become more fit for purpose and provide better support to patients and their relatives and friends.

It is suggested that action is needed now on three separate levels:

(i) At local level, with hospitals being required to draw up action plans to respond to the audit as they interpret it for their facilities, by a certain date, their progress and response to be reviewed by a nominated Director to ensure that they address the report. In this context the Director would be required to confirm the identification of priorities, the timescale adopted and the outcomes to the centre and thus be accountable for its adequacy and ultimate implementation.

(ii) At national level, mainly involving the allocation of sufficient resources; the production of standardised templates for various forms and policies; and the design and passage of the necessary legislation to provide a coherent overall policy framework.

(iii) And finally a comprehensive audit by the HSE of the progress made by hospitals in implementing those policy reviews identified as important in the various parts of Section B, to take place 6 months after the publication of this report.

Section B Annexes

Annex 1: Policies and Procedures (Non-exhaustive list)

- Mortuary facilities
- Last Offices
- Last Offices – Child and baby deaths
- Removing a body to the Mortuary
- Patient's valuables
- Infection control and laying out the deceased patient (with or without known infections)
- Care of mother and baby in the event of miscarriage and stillbirth
- Stillbirth and miscarriage policy
- Completing a cause of death form & information leaflet
- Decontamination of body/body fluid and urine spillages
- Dealing with a chemical spill
- Preparation for and performance of a post-mortem examination
- Arrangement of a post-mortem examination
- Health and Safety in the mortuary
- Embalming
- Mortuary maintenance
- Storage and disposal of limb amputations
- Interaction/communication with funeral directors
- Out of Ireland burial or cremation
- Tissue removal form
- Tissue returned to patient/next of kin
- Burial/disposal Consent Form
- Hospital guidelines and procedure in the event of adult death
- Autopsy management (Coroner's Post Mortem Examinations/Non Coroner's-Hospital Post Mortem Examination including all documentation)
- Mortuary and post-mortem examination facilities, (The facilities, the post-mortem suite/s, the mortuary and staff facilities-hygiene maintenance/floors/cleaning/drainage/health and safety/storage/ventilation)
- Perinatal autopsy consent form
- Paediatric consent form
- Adult consent form
- Procedure for the burial of retained post-mortem examination tissues or slides or blocks arising from organ retention enquiries
- Management of retained organs
- Adverse incident reporting
- Management of viewing of a deceased patient
- Guide for parents/guardians to the post-mortem examination procedure involving a child
- Consent form and information leaflet for retention of organs
- Pre autopsy checklist for consultants
- Disposal of clinical waste
- Quality manual health and safety statement
- Management of pathology laboratory
- Internal quality audit performance of an autopsy in post mortem examination suite
- Management of the mortuary
- Personal Protective Equipment (PPE)
- Equipment inventory for post-mortem examination suite

- COSHH
- Personal care
- Trained personnel form
- Transport and specimens
- Disposal of waste
- The refrigeration, body storage and handling area
- The viewing of a body and viewing facilities
- Decontamination of instruments
- Infection control
- Security
- Operating equipment
- Cut up
- Observation criteria/teaching facilities
- The post-mortem examination and the removal, retention, storage and use of organs and tissue
- Disposal of tissue including residual tissue
- Mortuary documentation and collection of activity data
- Care Pathway for patients experiencing a stillbirth
- Social Work bereavement guidelines
- Background Information and procedures for the book of remembrance
- Checklist following the death of a baby or child
- Use of Quiet Room
- Interpretation Service
- Clinical Incident forms colour coded for each dept
- Caring for a terminally ill child and their family
- Recurrent miscarriage
- Caring for and supporting parents experiencing an intrauterine death, stillbirth or neonatal death
- Caring for and supporting parents experiencing a miscarriage
- Maternity social services
- Policy on patient complaints
- In house guide to complaints management
- Deaths reportable to the coroner
- Referral to bereavement counselling
- GP's Letter; Postnatal review visit following a babies death
- Training card for labour ward, theatre, postnatal, antenatal areas
- Incident reporting form
- Consent for hospital burial of baby checklist: early miscarriage for post-mortem examination
- Intensive care unit/ward- discharge/transfer of a body to the mortuary
- Child brought in dead to Accident and Emergency
- Sudden and unexpected deaths
- Policy review document
- Policy for dealing with past organ retention cases
- Care of the deceased in Theatre
- The procedure for fetal parts identified at Histological Examination

For every policy there is a post-mortem staff training record (very good practice)

Annex 2: Minimum Information to be included in logs

Deceased persons register:
Name
Address
Date of Birth
Occupation
Date of death
Place of death
Brief circumstances
If a post-mortem examination is to take place
Funeral director
Bodies logged in and out of mortuary facility
Released and collected by whom
Signed for by the person collecting
Date
Time.

Post-mortem examination register:
Name
Post-mortem examination number
Address
Date of Birth
Date of Death
Coroners or hospital post-mortem examination.
Signature to state has a copy of consent or Coroners authorisation (fax/email or verbal)
Pathologist
Technician
Date of post-mortem examination any organs or samples removed and retained -Confirmation logged in retained organ log/register.

Organ retention register:
Date of post-mortem examination and removal of organ
Post-mortem examination number
What organ/s were removed and retained at post-mortem examination
Discussion with relatives
Who had the discussion
Wishes/choice of disposal/ donation
Notes regarding retention period
Notes of referral to other site
What organs were released
Date of release
Mode of disposal of organ/s
Who arranged and completed disposal.

An electronic database removes the need for much of the duplication that arises in multiple hardback registers.

Annex 3: Record Keeping

Record keeping:

1. Should be started at the initial point of contact
2. Should be written immediately after contact
3. They should be as contemporaneous as possible
4. If the notes are not able to be written immediately there should be a note as to why there was a delay
5. They should be timed, dated and initialled after each entry
6. They should be concise and accurate
7. Legible
8. Logical sequence
9. All writings should be in permanent ink
10. Any mistakes should be crossed out (single line) and initialled, not liquid corrected
11. All pages should be numbered and have the patients name, date of birth and hospital number on each page
12. If recording in a log ensure every section is completed and signed

Never use abbreviation unless they are locally agreed abbreviations i.e. ITU (transferred from Intensive Therapy Unit in hospital setting).

Document version control minimum

- Department
- Document title
- Author date
- Document no
- Number of revisions
- Number of pages
- Authorised by date
- Date of issue
- Review date
- Supersedes
- Document routing draft date ... signed
- Released date signed
- Approved / ratified date signed
- Distribution date signed

This is important but it is also important that the processes are truly embedded within the organisation, that staff know and understand the process and improve quality of services.

Annex 4: Retention of Organs at Post-Mortem Examination – Hospital Post-Mortem Examination

The person responsible within the hospital should contact the family i.e. the Anatomical Pathology Technician, Bereavement officer or medical social worker should contact the person nominated on the information sheet to:

- Report that the post-mortem examination has been completed and no organs have been retained and as good practice dictates small pieces of tissue in tissue blocks and blood samples were retained. They should have been informed of this prior to the post-mortem examination taking place (as part of the process of seeking consent) or, (in the case of a coroners post-mortem examination who spoke to the family to inform them that a post-mortem examination had been requested) and be aware that this is good standard practice in all post-mortem examinations.
- An organ or organs has had to be retained for what purpose and expected duration.
- There is a choice element here as to whether there is discussion at this point with regard to the disposal of the organ(s) or whether the family is informed that they will be sent a letter detailing what their options are with regard to disposal of the organs(s). Either way the conversation should be supported in writing with a contact number should they wish to discuss further.
- Follow up support should be offered and a progress report in an agreed format should be arranged i.e. a letter will be sent to the hospital at time of disposal if hospital disposal is chosen or i.e. an organ being referred to X Hospital for specialist examination, a letter will be sent to say when it has gone to X hospital including the estimated expected time to be at X hospital and letter will be sent upon return and organ is ready for release for burial.
- The point, the Next of Kin are kept informed as to what is happening, should they choose not to be informed, that should be noted on the file and abided by.

This works well in some hospitals for example St. James Hospital and Children's University Hospital Temple Street has an exceptionally high standard and should be considered exemplar sites in this regard, other hospitals also have very good practice such as Beaumont Hospital.

References

1. All internal viscera dissected- definition of internal viscera is different and can be some of the internal organs or all.
2. Eastern Regional Health Authority minutes of meeting in Tullamore. 24th March 2004.
3. Professor Ian Kennedy – Bristol Royal Infirmary Inquiry – Summary pg.2 Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995; CM 5207(I) HMSO July 2001.
4. Mr. Michael Redfern Q.C. The Royal Liverpool Hospital Children's Inquiry Report pg 4 HMSO 2001.
5. Report of Dr Deirdre Madden on Post Mortem Practice and Procedures. 21st December 2005.
6. Report of the working group on Post Mortem Practice. 6th November 2006.
7. 'The Faculty of Pathology of the Royal College of Physicians of Ireland' Guidelines for post mortem consent and the retention of samples. February 2000.
8. Consent for a post mortem examination should be requested by: a senior member of the medical staff caring for the patient. (Evidence suggests that this is the policy in virtually every hospital.) Pathologists have a duty of education to medical, nursing and paramedical staff about the purpose and nature of autopsy practice to facilitate informed discussion with relatives at time of death.
9. Eastern Regional Health Authority. Protocol/Guideline for hospitals and other relevant agencies in providing a quality response to families in relation to non-coroners post mortem practices. December 2002.
10. Organ is to be interpreted as a part of the body composed of more than one tissue that forms a structural unit responsible for a particular function, for example, the brain, heart, lungs and liver. Report of Dr Deirdre Madden on Post Mortem Practice and Procedures Pg. 21.
11. The audit tool provided by the University Children's Hospital to the audit team 28.11.07.
12. The audit tool provided to the audit team by CUH and Maternity services, CUH 31.07.07.
13. The audit tool provided by Kerry General Hospital to the audit team18.7.07.
14. The audit tool provided by Our Lady of Lourdes Hospital to the audit team 24.9.07.
15. The audit tool provided to the audit team by the Mercy Hospital Cork 30.7.07.
16. Portfolio of information provided to the audit team by MWRH Dooradoyle 13.12.07.
17. The audit tool provided to the audit team by MWRH Dooradoyle 13.12.07.
18. Audit tool provided to the audit team by MWRH Maternity Hospital 13.12.07.
19. Audit tool provided to the audit team by MRH 08.08.07.
20. All internal viscera dissected- definition of internal viscera is different and can be some of the internal organs or all.
21. Mortuary Procedures provide as a portfolio of evidence to the audit team 3/12/07.
22. Consent form provided to the audit team by Naven Hospital 28.9.07.
23. Audit tool provided to the audit team by Sligo Hospital 21.11.07.
24. All the internal viscera dissected, from another jurisdiction.
25. Audit tool provided to the audit team by SVH Group 17.10.07.
26. 'Consent for a post mortem examination should be requested by: a senior member of the medical staff caring for the patient. (Evidence suggests that this is the policy in virtually every hospital.) Pathologists have a duty of education to medical, nursing and paramedical staff about the purpose and nature of autopsy practice to facilitate informed discussion with relatives at time of death. The consent for use of tissue for teaching and/or research must be specifically sought. This has happened in limited cases - most consent forms include research. An information sheet containing information regarding the legal and practical aspects of both autopsy, funeral arrangements, death certification and the disposition of organs retained during the procedure should be available to staff and relatives.'
27. Eastern Regional Health Authority, a 'protocol/guideline for hospitals and other relevant agencies in providing a quality response to families in relation to coroners post mortem practice. December 2002.
28. "The Role of the Coroner in Death Investigation "2ndED, 2001, (section 4).
    'In the case where a post mortem examination or special examination has been performed on the body, whether organs, tissue or other material has been removed from the body or retained after the completion of the post-mortem examination or as the case may be, special examination in order to further the investigation into the death or any criminal investigation or to prevent further deaths'.

‘in a case where a post-mortem examination or special examination may be performed on the body that there is a possibility that organs and tissue and other material may be removed from the body and retained after the completion of the post-mortem examination or, as the case may be, other special examination, where it is necessary to do so in order to further the investigation in to the death or any criminal investigation or to prevent further deaths and for no other purpose.

‘the information in subsection (1) shall, in so far is practicable, be in a form and language likely to be understood by the person or persons to who it is provided’

‘where a coroner is conducting an investigation into the death of a person he or she shall, in so far as is practicable, continue to inform any person to whom information has been given under subsection (1)as to the progress, including the conclusion of the investigation.’

29. HBN20 ‘Facilities for Mortuary and Post-Mortem room services.
30. Health Service Employers Agency O\SHARED\PERSNL\CIRCULAR\NONOFFICE\CIRC99\84-99.