Using the HSE Incident Management Framework to Review Deaths Reported as Suspected Suicide within the Community Mental Health Setting

A Guide for Staff

Contents

Terms, Definitions and Abbreviations

Adverse Event	An incident which resulted in harm to a patient (WHO Global Patient Safety Strategy 2021-2030).
Category 1 incident	Incidents are categorised in accordance with the level of harm impacted on the person affected, as per the HSE Risk Impact Table; e.g., a death is rated as extreme and categorised as a Category 1 incident.
Clinical Lead	The Consultant Psychiatrist is the Clinical Lead for the multi-disciplinary care and interventions provided by the Community Mental Health Team.
Community Mental Health Team	The Community Mental Health Team (CMHT) aims to deliver integrated care to service users in their home, community settings and during inpatient treatment. Community Mental Health Teams consist of multidisciplinary staff and provide services in out-patient clinics, day hospitals, day centres and home setting within a community of approximately 50,000 population.
Community Response Plan	A Community Response Plan (CRP) is a coordinated, multi-agency response where there is an emerging risk of clusters and/or contagion of incidents of suspected suicide within the community (see suicide contagion below).
HSE Incident Management Framework (IMF)	Provides an overarching, practical approach, based on best practice to assist all HSE and HSE funded providers to comply with HSE incident management requirements.
HSE Incident Management Policy Statement	The Incident Management Framework contains a policy statement applicable to all HSE and HSE funded providers stating that all Incidents are identified, reported and reviewed so that learning from events can be shared to improve the quality and safety of services.
HSE National Office for Suicide Preventions (NOSP)	The HSE National Office for Suicide Prevention's (NOSP) role is to strategically lead on suicide prevention across the HSE and in collaboration with multiple sectors. The work of the office is underpinned by *Connecting for Life*, Ireland's National Strategy to reduce Suicide.
Incident	'An event or circumstance which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events which result in harm; near misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be clinical or non-clinical' (Incident Management Framework 2020).
Key Worker	A Key Worker is the member of the Multidisciplinary Team who co-ordinates an integrated care and recovery plan and acts as the link/contact for the service user whom they are supporting, their family, carers, advocate and other team members.
The National Incident Management System (NIMS)	The National Incident Management System is a web-based database which facilitates direct reporting of patient and staff incidents by state authorities such as the HSE. It is the single designated system for reporting of all incidents in the public healthcare system i.e. for HSE and HSE funded services.
Notifiable Incident:	Notifiable Incidents are pre-defined as such by the Department of Health and are listed in Schedule 1 of the Patient Safety (Notifiable Incident and Open Disclosure) Act 2023
Open Disclosure	Open disclosure is defined as an open, honest, compassionate and timely approach to communicating with patients and, where appropriate, their relevant person following patient safety incidents and notifiable incidents. It includes expressing regret for what has happened, keeping the patient informed and providing reassurance in relation to on-going care and treatment, learning and the steps being taken by the health and social care service provider to try to prevent a recurrence of the incident (HSE 2024)

Patient Safety Incident	A patient safety incident is defined by the Civil Liability (Amendment) Act 2017), which was amended by the 2024 Patient Safety [Notifiable Incidents and Open Disclosure] Act 2023. It is defined by Part 4, Section 7 of the Civil Liability (Amendment) Act 2017) as follows: In this Part, 'patient safety incident', in relation to the provision of a health service to a patient by a health services provider, means: (a) an incident, other than a notifiable incident, which has caused an unintended or unanticipated injury, or harm, to the patient and which occurred in the course of the provision of a health service to that patient, (b) an incident, other than a notifiable incident: (i) which has occurred in the course of the provision of a health service to the patient and did not result in actual injury or harm, and (ii) in respect of which the health services provider has reasonable grounds to believe placed the patient at risk of unintended or unanticipated injury or harm, Or (c) the prevention, whether by timely intervention or by chance, of an unintended or unanticipated injury, or harm, to the patient in the course of the provision, to him or her, of a health service, and in respect of which the health services provider has reasonable grounds for believing that, in the absence of such prevention, could have resulted in such injury, or harm, to the patient. *(Civil Liability (Amendment) Act 2017) revised 2024*
Postvention	An organised response in the aftermath of a suicide to accomplish any one or more of the following: • To facilitate the healing of individuals from the grief and distress of suicide loss • To mitigate other negative effects of exposure to suicide • To prevent suicide among people who are at high risk after exposure to suicide. https://sprc.org/comprehensive-approach/postvention
Relevant Person	"Relevant person", in relation to a patient, means a person: (a) who is: (i) a parent, guardian, son or daughter, (ii) a spouse, or (iii) a civil partner of the patient, (b) who is cohabiting with the patient or (c) whom the patient has nominated in writing to the health and social care service provider as a person to whom clinical information in relation to the patient may be disclosed. *(Civil Liability (Amendment) Act 2017)* Note: This definition is distinct from the definition of the "relevant person" in the Assisted Decision Making Capacity Act 2015.
Review Commissioner	The person who commissions and incident review. For category 1 incidents it is the Senior Accountable Offence (SAO) or a person who has the direct reporting relationship to the SAO. For category 2 incidents it is the Local Accountable Officer.
Senior Accountable Officer (SAO)	In context of the management of an incident the Senior Accountable Officer is the person who has ultimate accountability and responsibility for the service within the area where it occurred.
Serious Incident Management Team (SIMT)	A Serious Incident Management Team is a group whose role is to oversee the management of all serious incidents relating to the service.
Serious Reportable Events (SREs)	These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Service User	Service user refers to a member of the public who is in receipt of the services provided by the mental health service.
Service User Designated Person	This person is a contact point for the service user/their relevant person(s) impacted by an incident.
Statement of Findings	Within context of system analysis reviews, a statement of findings describes the relationship between the contributing factors and the incident and/or outcomes.
Staff Liaison Person	This person is a contact point at service delivery level for the staff member involved in an incident.
Suicide/die by Suicide	Suicide is death resulting from an intentional, self-inflicted act.
Suicide Cluster	A suicide cluster refers to a series of three or more closely grouped suicides that are linked psychologically and/or by locality and/or by social relationships. Not all suicides that occur in clusters are the result of suicide contagion.
Suicide Contagion	Suicide contagion describes the risk associated with the knowledge of another person's suicidal behaviour, either first-hand exposure or through the media. There are many potential uses of the term suicide contagion which are outlined in the HSE Developing a Community Response to Suicide (2021).
Suspected Suicide	While not a definition, the term, 'suspected suicide' is used throughout the document as deaths by suicide may only be determined by a Coroner's inquest, which could take place months after the person's death. The death of a service user by suspected suicide that takes place within the community setting is also referred to as 'an incident' throughout this guidance document when outlining the service's response under the Incident Management Framework.
System Analysis	A method of incident review involving the collection of data from literature, records, individual interviews with those involved when the incident occurred and analysis of the data to establish the chronology of events that led up to the incident, identifying findings that the reviewer(s) considered had an effect on the eventual harm, the contributory factors and recommended actions to prevent future harm, as far as is reasonably practical.
Team Coordinator	Administrative and clinical role that can be fulfilled by any clinical member of the CMHT with the relevant organisational and clinical experience. Role includes but not limited to administration and triage of referrals in consultation with all CMHT members, managing waiting lists, organising meetings and Liaising with GPs and community agencies *(Vision for Change, 2006).*

Abbreviations

CHO	Community Health Organisation	NIRF	National Incident Report Form
CMHT	Community Mental Health Team	NOSP	National Office for Suicide Prevention
CRP	Community Response Plan	PAF	Preliminary Assessment Form
EAP	Employee Assistance Programme	ROSP	Resource Officer for Suicide Prevention
GDPR	General Data Protection Regulation	SAO	Senior Accountable Officer
HSE	Health Service Executive	SIMT	Serious Incident Management Team
IMF	Incident Management Framework	SRE	Serious Reportable Event
NGO	Non-Governmental Organisation	QSSI	Quality, Safety and Service Improvement
NIMS	National Incident Management System		

Foreword

In support of the HSE Patient Safety Strategy's, commitment to 'Reducing Common Causes of Harm', HSE Access & Integration has worked with the National Office for Suicide Prevention (NOSP) to develop this incident management guidance document specifically for use when there are deaths of mental health service users by suspected suicide that take place within the community setting. The guidance has been developed in partnership with the National Quality and Patient Safety Directorate's Incident Management Team and other relevant stakeholders, including service representatives.

In the aftermath of the death of a mental health service user by suspected suicide within the community setting, the welfare and support needs of all those affected are a primary concern for Community Mental Health Services. In addition, within HSE and HSE funded services, there are statutory[1] and organisational responsibilities to identify, report and review such deaths by suspected suicide as part of an incident management process. The aim of this is to establish if there is any learning from such events that could improve quality and safety for other service users and specifically, in the case of suspected suicide to contribute to learning related to suicide prevention.

The HSE Incident Management Framework[2] provides services with an overarching, practical approach to comply in a consistent manner with statutory and HSE requirements in relation to managing incidents.

This guidance document has been aligned with the Incident Management Framework, the National Standards for the Conduct of Reviews of Patient Safety Incidents, set by the Health Information and Quality Authority and the Mental Health Commission and also, the HSE operational guidelines for Developing a Community Response to Suicide.

The need for timely monitoring of data relating to incidents presenting as suicide is also emphasised in the National Mental Health Policy, Sharing the Vision, a Mental Health Policy for Everyone and refers to international recognition that the learning outcomes from the review of such incidents within Mental Health Services can contribute positively to strategic safety improvements.

Connecting for Life, the National Suicide Reduction Strategy, also includes a specific goal aligned to improving the overall quality of data related to suicide in its strategy[3]. The HSE are also working in this area, and currently undertaking a feasibility study for a National Suicide Register – with stakeholder engagement on this planned by our academic partner during 2024.

With improved consistency in how incidents of suspected suicides within the Community Mental Health Services are reported, and reviewed, the quality of data relating to incidents of suspected suicide should likewise improve. This in turn provides the potential for learning, leading to data driven suicide reduction interventions in mental health services. I would like to thank the working group members and those across the country who piloted the guidance for their time and contribution.

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Assistant National Director, Access and Integration

1 National Treasury Management Agency (NTMA) (Amendment) Act 2000. Section 11
http://www.irishstatutebook.ie/eli/2000/act/39/enacted/en/html
2 The Incident Management Framework is reviewed and updated at regular intervals.
Please consult the HSE website for the most up to date version.
3 Connecting for Life, Goal 7 'Better Data and Research':
https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/better-data-and-research/

Introduction

The overall purpose of the guidance is to support Community Mental Health Services to effectively utilise the Incident Management Framework as part of the service's overall response when there is a sudden or unexpected death of a service user by suspected suicide that takes place within the community setting. The Guidance aims to promote:

- A compassionate, caring and person centred approach to those affected in the aftermath;
- Respect and sensitivity for the wishes and experiences of families/their relevant person(s) and staff throughout the incident management process;
- Awareness of HSE and community support services and resources available to those affected following the death of a service user by suspected suicide.
- A standardised and proportionate response to operating the HSE Incident Management Framework, across all services;
- Informed incident management decision making;
- Learning from the review of incidents that identifies good practices and areas for service improvement with regard to suicide prevention;
- Improved quality of data relating to suspected suicides that can contribute to mental health policy and suicide prevention strategies;
- Confidence and trust in our governance and incident management processes;

Scope

This guidance document is available for all services, however its intended use is for HSE provided and HSE funded Community Adult Mental Health and Child and Adolescent Mental Health Services when there are sudden or unexpected deaths reported as suspected suicide that occur within the community setting.

Note – out of Scope: The guidance document is not intended for use when there is a death by suspected suicide of a person who is an inpatient/resident in a mental healthcare facility. Such incidents belong to a subset of all serious incidents described by the HSE as Serious Reportable Events (SREs[4]). Such incidents should always be reported and managed in accordance with HSE guidance for serious reportable events.

Following the commencement of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023, any 'unintended death where the cause is believed to be the suicide of a patient' while being cared for in an HSE or HSE-funded setting could be a notifiable incident. It is important that the management of the notifiable incident is pursued in-line with the process set out in the Act. This includes notification to the relevant regulator of the notifiable incident and mandatory open disclosure. Further information can be found here.

4 Serious Reportable Events (SREs). https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/sre-guidance-january-2015-v1-.pdf

Format

The document is divided into two sections

Part A

Part A guides staff through the 'six steps' of the Incident Management Framework. It emphasises adherence to governance processes and a proportionate response to incident management.

A **preliminary assessment form** has been adapted to gather information relevant to the context of the care received by the service user. This aims to support teams when determining if a patient safety incident has occurred which may require an incident review and if so, the level of review required.

A core principle of the Incident Management Framework is a person-centered approach. The guidance reinforces the inclusion of the bereaved family/their relevant person(s) and staff involved in the service user's care at all stages of the incident management process and the need for those managing the response to maintain ongoing, open and compassionate communication with all those affected.

Part B

Part B focuses on providing:

Postvention information, resources and supports available to those impacted by the death of a service user by suspected suicide which includes families/their relevant persons, staff and the wider community.

Postvention refers to organised responses in the aftermath of a suicide or suicide attempt which can facilitate healing from grief and loss for those affected and which can prevent suicide or self-harm among people who are at high risk after exposure to suicide[5].

5 US National Guidelines 2015. Responding to Grief, Trauma and Distress after a Suicide: https://www.sprc.org/resources-programs/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines

Part A – Incident Management Framework

Overview of the Incident Management Process

The Incident Management Framework sets out the principles, governance requirements, roles and responsibilities and the processes for incident management.

VALUES			
The Incident Management Framework is underpinned by the HSE values of:			
CARE	**COMPASSION**	**TRUST**	**LEARNING**

Principles	Principles
Person-centredness	Responsive
Fair and just	Improvement focused
Openness and transparency	Learning

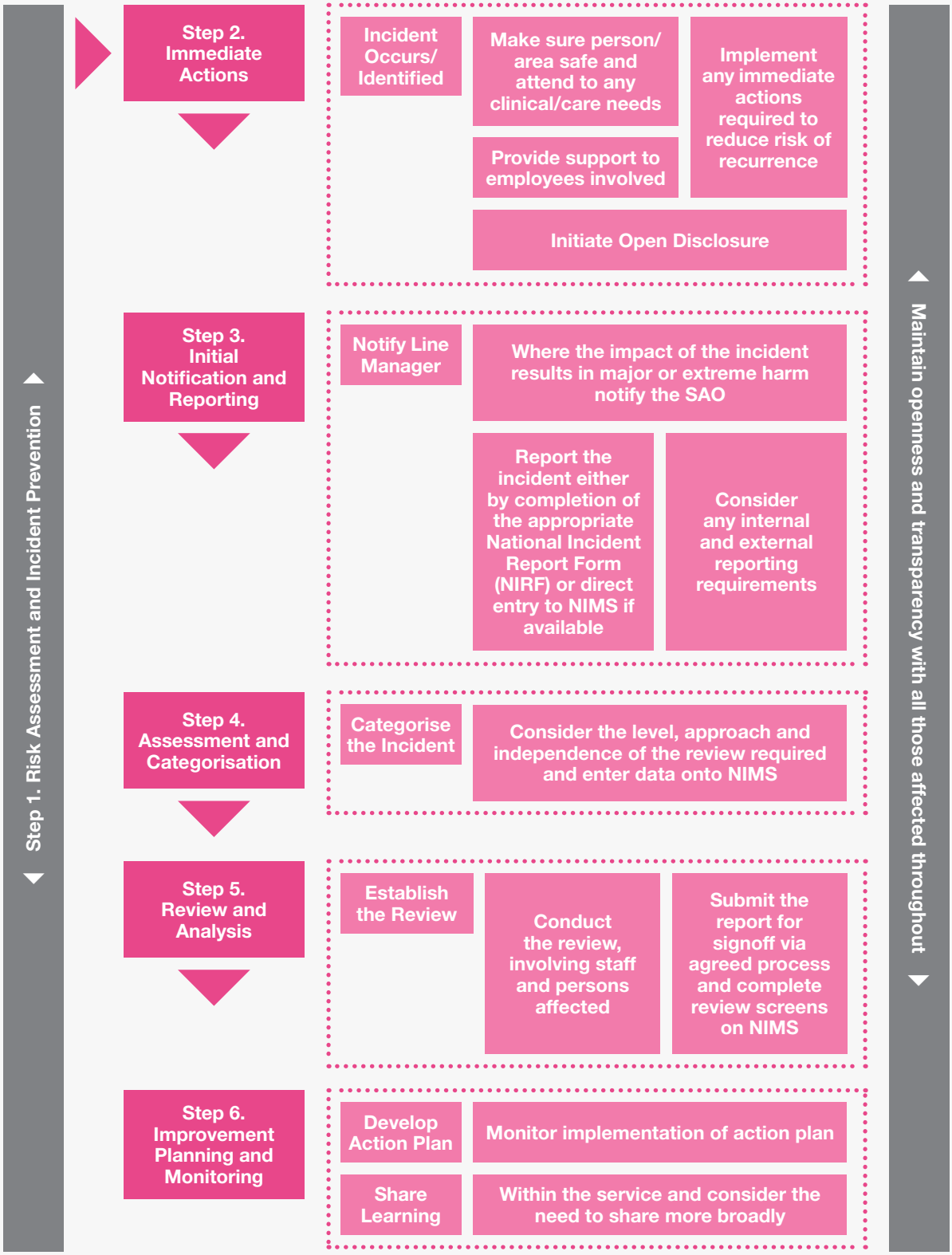
'Six Steps':

The Incident Management Framework describes six steps in the process for managing an incident (see Diagram 1). Regardless of their impact, all incidents require management in line with the following steps:

1. Prevention through supporting a culture where safety is considered a priority.
2. Identification and immediate actions required (for persons directly affected and to minimise risk of further harm to others).
3. Initial reporting and notification.
4. Assessment and categorisation.
5. Review and analysis.
6. Improvement planning and monitoring.

While every incident requires a response, this should be proportionate to the impact, scale, complexity and potential for improving the safety of the service and service learning.

Diagram 1


Step 1. Risk Assessment and Incident Prevention
Step 2. Immediate Actions
Incident Occurs/ Identified
Make sure person/ area safe and attend to any clinical/care needs
Provide support to employees involved
Implement any immediate actions required to reduce risk of recurrence
Initiate Open Disclosure
Step 3. Initial Notification and Reporting
Notify Line Manager
Where the impact of the incident results in major or extreme harm notify the SAO
Report the incident either by completion of the appropriate National Incident Report Form (NIRF) or direct entry to NIMS if available
Consider any internal and external reporting requirements
Step 4. Assessment and Categorisation
Categorise the Incident
Consider the level, approach and independence of the review required and enter data onto NIMS
Step 5. Review and Analysis
Establish the Review
Conduct the review, involving staff and persons affected
Submit the report for signoff via agreed process and complete review screens on NIMS
Step 6. Improvement Planning and Monitoring
Develop Action Plan
Monitor implementation of action plan
Share Learning
Within the service and consider the need to share more broadly
Maintain openness and transparency with all those affected throughout

IMF Step 1: Suicide Reduction through Supporting a Culture where Safety is a Priority

The National Suicide Reduction Strategy, *Connecting for Life* describes the complexity involved in every death by possible suicide. It refers to the multiple factors that can contribute to suicidal behaviour and that usually, no single cause or risk factor alone can explain a suicidal act.

Mental Health Services strive to reduce risks to suicide for service users. Managing and responding to known, evidence based risk factors of suicidal behaviour is one such way that the Mental Health Services positively support and provide interventions to service users at risk of suicide. Services also integrate the proactive management of risks to suicidal behaviour into how services are planned and delivered and into how environments are designed to improve safety.

Connecting for Life emphasizes the importance of working together with the Mental Health Services towards the common goal of suicide prevention.

Every potential incident is an opportunity for learning and service improvement.

To support a culture where safety is recognised as a priority, the Incident Management Framework provides clear procedures to allow incidents to be managed in a consistent manner that is respectful, fair and transparent to all of those affected.

However, in the first instance, to support a culture where safety is a priority, staff at all levels in the service need to feel psychologically safe to report incidents and to ask for help when faced with an issue beyond their competence. An environment where a '**just culture**'[6] is supported can enable staff to feel confident, to speak up, without fear of reprisal when they raise risk or safety concerns and when reporting incidents.

A culture within a service that is proactive, open to learning and to implementing changes will positively contribute to risk reduction in the area of suicide prevention.

A just culture in the organisation together with a culture of reporting and learning from incidents contributes to an overall patient safety culture.

6 The HSE Incident Management Framework (2020) defines Just Culture as one which refers to ***a values based supportive model of shared accountability***. Learn more about just culture: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/just-culture.html

IMF Step 2: Incident Identification and Immediate Actions Required

Verifying the Known Circumstances surrounding the Death of the Service User by Suspected Suicide

The member of the Community Mental Health Team (CMHT) who is first made aware of the service user's death or their keyworker should liaise with the treating Consultant Psychiatrist. The team will in turn verify the facts from reliable sources in relation to the known circumstances surrounding the service user's death. Information that comes from third party sources needs to be verified by a reliable source before it can be considered factual and accurate.

Some examples of reliable sources of information are:

- Family/their relevant person(s)
- Staff involved in the care of the service user
- General Practitioner (GP)
- An Garda Síochána
- Coroner's Office
- Other services involved in the care of the service user

Maintaining two way communication between all parties should be fostered in the interest of sharing and verifying information. The challenge in relation to the tragic deaths occurring of community mental health service users is that such deaths are not necessarily patient safety incidents. They are always catastrophic service user outcomes of course. Reporting such events, undertaking a preliminary assessment consistently and in some cases undertaking a system analysis review where care or service delivery issues have been identified will lead to learning and improvements and is proportionate in response.

Sudden, Unexpected Deaths of Unknown Cause

Occasionally, the CMHT becomes aware of a sudden, unexpected, death of unknown cause. For example, the scenario where a service user is found dead at home with no overt evidence that the death is due to either natural, accidental or self-harm.

Sudden, unexpected deaths of unknown cause should be reported and follow an incident management pathway. Following an incident management pathway means working through the steps of the Incident Management Framework, in particular undertaking a preliminary assessment, to aid decision making regarding if an incident has occurred, and if so – if a review is required, and what level of review this should be. Until the Coroner's verdict is issued, care needs to be taken not to make assumptions.

Immediate Actions

The Incident Management Framework reminds us that the immediate actions taken by services following a service user's death significantly influence the degree to which the service is viewed as supportive and trustworthy by those affected.

The emotional welfare and support needs of families/their relevant person(s) and the staff involved in the care of the service user is an immediate concern and contact should be initiated, as appropriate once the service user's death and relevant circumstances have been verified.

Communications and Open Disclosure

All communications with those affected in the aftermath should be open, honest and compassionate in a manner that is respectful, timely and sensitive to their needs and wishes. Communication should be initiated at the earliest stage possible with regard to the circumstances in each case.

Service User's Family/their Relevant Person(s)

- At an early stage, a member of the CMHT should make initial contact with the family/their relevant person(s) to offer condolences and support, either in person, within the home setting or by phone, as appropriate.
- Consideration should be given to the extent and nature of the previous relationship between the community mental health service and the service user and their family/their relevant person(s) in deciding who is best placed to initiate contact.
- Services need to be mindful that those bereaved may not always be able or ready to engage with the services or to take up an offer of support in the immediate aftermath.

Therefore, **initial communications**, whether in person or by phone should include a message of openness that:

- Indicates that the service will make further contact at a time that is suitable for the family/their relevant person(s);
- Includes a contact name and number for the bereaved family/their relevant person(s) should they wish to make contact themselves, at a later stage and in their own time.

An outline of useful bereavement and support resources is available in **Part B** of this guidance.

Cultural Awareness

Ethnic, cultural and religious diversity can influence the perception and experience of grief and bereavement amongst people who use and who work in our Mental Health Services.

In addition, staff can experience challenges in communicating at a sensitive time when English is not the first language of a family.

To support staff in dealing with such circumstances, there are a number of both intercultural and multilingual communication resources developed by the HSE and signposted to in **Part B** of this guidance. This includes a link to cultural awareness training resources available for staff.

Staff Involved in the Care of Service User

- **Line managers** of staff involved in the care of a service user should make contact with their staff to offer support and to ask staff what supports they feel they need.
- The role of the line manager in this regard is to ensure that staff do not feel isolated and that their support needs are met appropriately in the aftermath.
- **Line managers** should consider the need for psychological support and/or debrief for those affected and give information and/or activate supports services, as appropriate.

Links to supporting information and resources including Critical Incident Stress Management (CISM) and the Employee Assistance Programme (EAP) are included in Part B of this document.

Coordinated Team Communication Approach

The **Clinical Lead/Team Coordinator** should ensure that all of the members of the Community Mental Health Team are informed of the service user's death and kept up to date on immediate actions. This will assist in ensuring a cohesive team approach and that communications made with the family/their relevant person(s) and other service users who may be affected are made in a consistent and timely manner.

Timely contact should also be made by **line managers** with all **other relevant staff and services** who were involved in the care of the service user outside of the Community Mental Health Team to ensure that they are informed and so that they are alerted to assess and put supports in place for service users and staff who may be affected.

Confidentiality

Mental Health Staff are always bound by the principle of confidentiality in relation to current and former service users' information. Although the data of a deceased person is not subject to the General Data Protection Regulation (GDPR), the highly sensitive nature of the data and the need to maintain confidentiality (particularly in relation to the bereaved family) must be considered at all times. Further information regarding GDPR and the sharing of service user information within the context of suicide prevention and postvention is included in the HSE's guidelines on Developing a Community Response to Suicide (2021), available here.

Team Support: Community Mental Health Team Meeting

As soon as is practical in the aftermath of the service user's death, the **Clinical Lead/Team Coordinator** should plan for and facilitate a meeting with the team members in recognition that staff may need support and that as a team, they may need an opportunity to talk about coming to terms with the service user's death.

Documentation

As soon as possible, documentation in the service user's clinical file should include:

- The known facts of the occurrence of the suspected suicide;
- Any immediate actions taken or relevant information;
- All communications with the family/their relevant person(s) and when and how they took place. Record the key points discussed, including an expression of sympathy;
- Update documentation relating to the incident in the clinical file as further information is identified and/or further actions take place, including all communications with the family/their relevant person(s).

Summary Step 2: Incident identification and immediate actions required	
Key Actions	**Person(s) Responsible**
Verify circumstances of service user's death from reliable sources	CMHT/Keyworker
Initiate contact with family/their relevant person(s) to offer condolences and support	CMHT Staff Member/Keyworker/ Assigned CMHT member
Initiate contact and offer support to staff directly involved in service user's care	Line Managers
Inform all other members of Community Mental Health Team of service user's death	Clinical Lead/Line Managers
Allocate a designated person as described in the Open Disclosure Policy. Consider linking with HSE Regional Officer for Suicide Prevention to facilitate community supports; see Section B4	CMHT
Agree team approach to communications with service users affected, as required	CMHT
Agree team approach to communications with other service users and/or other services attended by service user, as required	CMHT/Line Managers
Plan and facilitate dedicated team support meeting	Clinical Lead/Team Coordinator
Document known facts of service user's death, all actions and communications with family/their relevant persons in clinical file	CMHT Staff Member

IMF Step 3: Initial Notification and Reporting

Reporting

Services have a responsibility to report all incidents within the organisation and to complete an incident report form.

The statutory obligation to report incidents to the State Claims Agency is fulfilled through the National Incident Management System (NIMS) once the details of an incident report form (NIRF) are inputted to the NIMS.

The staff member who becomes aware of the event should report the incident to their line manager, within twenty four hours or as early as possible.

Incident Report Form (NIRF)

- All suspected suicides should be reported on a 'Person' incident report form (NIRF 1) (or directly on to NIMS where electronic point of entry is available) by a staff member;
- Care and attention is needed to ensure that all information recorded on the NIRF is factually accurate, fair and objective;
- Only factual information surrounding the known circumstances of the service user's death that has come from reliable sources, as listed in Step 2, should be recorded in the description section of the incident report form;
- Anonymise the description of the incident and those involved – no names, no place names;
- All relevant fields should be completed on the NIRF to ensure accurate and timely data. This is necessary to contribute to the quality of aggregate data reviews;
- The timeframe for completion of the NIRF 1 and input of the details onto the National Incident Management System (NIMS) is within twenty four hours/one working day of the service becoming aware of the death of the service user by suspected suicide.

NIRF Forms are available on the HSE Incident Management website in both hard and soft copy[7].

Local Quality Assurance Arrangements

- Information recorded on the NIRF should be checked to ensure completeness and accuracy;
- The **Line Manager** of the reporting staff should review and sign off on the information recorded on NIRF;
- All staff should know where to send incident report forms (NIRF) for inputting onto the National Incident Management System (NIMS) and who is assigned to do this;
- Local procedures should be in place to ensure ongoing monitoring of NIMS to ensure that information is updated as the incident management process progresses.

7 NIRF Forms and further information on NIMS available at: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/national-incident-management-system-nims-.html

Category 1 Incident

When the details of the incident are inputted onto the National Incident Management System (NIMS), the death is automatically rated as an **extreme incident**, in accordance with the HSE Risk Assessment Tool[8].

The IMF categorises an extreme incident as a **Category 1** incident and therefore, reporting and management follows a serious incident management process.

Reporting Suspected Suicide to Senior Management and Senior Accountable Officer

Details of the roles and responsibilities associated with reporting and management of an incident reported as a Category 1 incident are outlined in the Incident Management Framework.

Within the context of a community death by suspected suicide within the Mental Health Services, they include:

- Line Managers have the responsibility to ensure that the senior clinical personnel and senior management within the community mental health service are informed of the suspected suicide and of the actions taken by the services after the event;
- Senior clinical/management personnel ensures that the suspected suicide is reported to the Senior Accountable Officer within twenty four hours or as early as possible, of the service becoming aware of the death;
- The role of the Senior Accountable Officer is usually designated to the Head of Service for Mental Health in relation to the management of serious incidents;
- Management should ensure that there are local procedures in place for clear communication routes when reporting such serious incidents outside of working hours and at weekends.

External Reporting of Suspected Suicide

The community mental health services are no longer required to submit notifications to the Mental Health Commission (MHC) on suspected suicides that occur in the community.

The guidance for the MHC's Comprehensive Information Service (CIS) submissions applies to approved centres primarily and can be found here: https://www.mhcirl.ie/sites/default/files/2024-09/MHC_QSNGuidance_September2024.pdf

As stated, the provisions of the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 define reporting requirements of notifiable incidents for all services. This applies to community mental health services who must report notifiable incidents, should they occur, to HIQA on the National Incident Management System (NIMS). The list of notifiable incidents can be found here.

Notifiable Incident 1.12 describes an event whereby a person dies by suspected suicide. For this to be deemed a notifiable incident the death must have occurred in or at a place or premises in which a health services provider provides a health service. That would exclude deaths where the death occurs in public spaces. Even though a death that occurs in a public space is not a notifiable incident, it may still be an incident for review under the Incident Management Framework. This Guide is aiming to address that and support staff in their decision making.

8 HSE Risk Assessment Tool: https://www.hse.ie/eng/about/who/riskmanagement/risk-management-documentation/hse-enterprise-risk-management-supporting-tools/

Other External Agencies

While in many cases, it may be the family or GP who informs the Mental Health Service of the service user's death and that reporting to both the Coroner and An Garda Síochána will already have taken place, there may be some circumstances under which the service becomes aware of the death, when the Clinical Lead may need to ensure that the service user's death has been reported to the Coroner and to An Garda Síochána.

The Incident Management Framework provides further guidance on reporting requirements for a range of external agencies, when required.

Summary Step 3: Initial Notification and Reporting	
Key Actions	**Person(s) Responsible**
Accurate, anonymised, factual completion of NIRF (person)	CMHT Member
NIRF signed by Line Manager	Line Manager
Quality Assurance of NIRF data	Line Manager/QPS
Input NIRF details to NIMS	QPS Support
Senior Clinical and Management Staff informed	Line Manager
Senior Accountable Officer/Head of Service Informed	Senior Clinical/Management
External Statutory Reporting to Mental Health Commission	Consultant Psychiatrist
External Reporting to Coroner, An Garda Síochána, other if required	Clinical Lead

Quality and Patient Safety Advisor/Manager

Throughout the incident management process, the Quality and Patient Safety Advisor/Manager is available to actively guide and facilitate the Mental Health Service on all aspects of incident management, reporting and associated risk management.

They can also advise on the quality of data on the NIRF before input onto NIMS and on the updating and monitoring of data quality.

They provide expertise to assist decision making at the serious incident management team (SIMT) meetings and frequently play a coordinating role as either the person assigned by the Senior Accountable Officer or as support to those assigned to gather the background information and assurance in relation to actions taken in the aftermath of the incident.

Quality and Patient Safety Advisors/Managers play active roles in incident management reviews and in the implementation of the learning from reviews to improve safety.

IMF Step 4: Categorisation and Initial Assessment

Governance for Serious Incident Management

Senior Accountable Officer (SAO)

When the SAO/Head of Service for Mental Health is made aware of a death by suspected suicide within the community setting, they should **seek assurance** from the service that:

- Contact and open, supportive communication has been initiated with all those affected, or that there is a documented reason for why this has not happened in the immediate aftermath
- Any immediate safety concerns for those affected by the service user's death that have been identified are being addressed, such as the need for psychological support.

To prepare for **assessment and decision making** in relation to further management and review of the service user's death, the SAO should:

- Assign a staff member to collaborate with the Community Mental Health Team to gather and document factual information related to the incident, its immediate management and the background to the service user's care within the service.
- Convene a Serious Incident Management Team meeting within seventy two hours or at least within five working days of becoming aware of the incident.

Serious Incident Management Team (SIMT)

The SIMT is an integral part of the overall governance of serious incidents with a defined role in the initial management of all new, Category 1 incidents and their ongoing management[9].

Serious Incident Management Team Membership

- As recommended by the Incident Management Framework, the SIMT is chaired by the SAO/ Head of Service for Mental Health. This SAO delegation may change in line with the establishment of the six Health Regions – this should be recorded and communicated locally pending review of the IMF and its related guidance documents.
- The core membership of the SIMT should always include nominated members of the Mental Health Executive Management Team including the Executive Clinical Director/ Clinical Director, Director of Nursing and other relevant Heads of Discipline.
- The Quality and Safety Manager/Advisor is also a core member to guide the incident management process.
- The SIMT should always include the relevant clinical expertise to support decision making from a senior clinician who was not directly involved in the service user's care at the time of their death.
- The membership of the SIMT may need to be reviewed to include other relevant expertise from across all disciplines, including for example pharmacy in order to assist the team in making informed decisions.

9 In line with the IMF, the SIMT meets on a scheduled basis to monitor and gain assurance in relation to the ongoing management of all Category 1 incidents within the service. The SIMT also convenes on an unscheduled basis within 5 working days of a Category 1 incident.

Preliminary Assessment

Gathering Information - a collaborative approach

The person assigned to gather information in preparation for the SIMT's meeting needs to collaborate with the members of the **Community Mental Health Team** who are familiar with the service user's engagement and their clinical care. Other sources of relevant information include but are not limited to:

- Information received from the **family/their relevant persons** in accordance with their consent and expressed wishes for such information to be considered in the assessment
- Incident Report Form/National Incident Management System
- The service user's clinical file
- Relevant policies and procedures.

Preliminary Assessment Form for Incidents of Suspected Suicide within Community Mental Health Settings

To assist Community Mental Health Services, the Incident Management Framework's generic Preliminary Assessment Form has been adapted to guide and document the information gathered in advance of the SIMT's review decision making meeting, as described below:

Part A of the Preliminary Assessment Form has been enhanced to focus on information relevant to the community mental health setting and contains:

- The '**Background to the Incident**' section with **guiding headings** and **prompt questions** relating to the service user's care and engagement with the Mental Health Service, in the time leading up to their death.
- **A checklist of** '**actions taken**' in the aftermath relating to compliance with the Incident Management Framework.

The Community Mental Health Team are best placed to collaborate with the assigned staff member in the completion of Part A of the Preliminary Assessment Form.

Part B and Part C of the Preliminary Assessment Form are used by the SIMT at their meeting to:

- Document the decisions taken at the SIMT meeting in relation to the need to undertake a further review or not and the type and level of review required.

Where to find the Preliminary Assessment Form for Incidents of Suspected Suicide within Community Mental Health Settings

The full version can be found in Appendix 2 of this document. A word document version is also available to allow text entry – with the field boxes expanding as required to fit text

SIMT Decision Making

When the SIMT has received and considered all the information recorded on Part A of the Preliminary Assessment Form, they will be supported to assess the known facts surrounding the death of the service user and to take any concerns that may be raised by the family/their relevant person(s) and staff into consideration.

On occasion, the SIMT may need to request further information before making a decision regarding the need for further management and review.

Healthcare Improvement Scotland offers some general 'decision making prompts' for guidance in relation to deciding on the appropriate level of review required following a suspected suicide which may be helpful for the SIMT:

- *Are there any 'unknowns' in relation to the event?*
- *Has there been any breach or deviation in policy or procedure?*
- *Is there learning to be gained/would you do anything differently in similar circumstances?*
- *Do family members and carers have any concerns regarding the event?*

SIMT Decision: No further review required

Due to the complexity involved in every death by suspected suicide, not all suspected suicides that occur within the community setting are patient safety incidents and therefore, may not require an incident review beyond the requirement for a preliminary assessment.

Before a decision may be taken that the suspected suicide does not warrant further review, the SIMT should be assured from their thorough assessment that no omissions or actions in the system of care can be identified. Such a decision can be supported when following the review of all available information gathered, that:

- The known circumstances of the service user's death are clear;
- The views expressed by the family/their relevant person(s) and/or staff do not indicate concerns;
- The documented contact and care received from the services do not indicate any potential patient safety concerns;
- The service user's death was not associated with circumstances in the delivery of care which *'could have, or did lead to unintended and/or unnecessary harm'*[10];
- The service would have done anything or delivered care differently in similar circumstances.

10 Definition of an incident, HSE Incident Management Framework (2020).

Steps following a decision of 'no further review' include:

- Communicate this decision and rationale to the family/their relevant person(s) with the support of the designated person and staff involved in service user's care;[11]
- Communicate this decision and rationale to the local Community Mental Health Team;
- Refer the SIMT's decision to the Quality and Safety Committee for their consideration along with a copy of the completed preliminary assessment form and any noted learning for service improvement;
- The decision 'no further review', when ratified by the Quality and Safety Committee, should always be recorded on the NIMS review screens to ensure accurate data quality.

Should new information come to light, the SIMT may need to revisit a 'no further review' decision.

SIMT Decision: approach to review agreed

Where the SIMT determine that an incident review is required this will likely be taken in situations:

- When the SIMT are not assured from their preliminary assessment that omissions or actions in the system of care have not taken place;
- Family/their relevant person(s) and/or staff have expressed valid patient safety concerns;
- Where the documented care and contact with the service user indicate potential concerns regarding the service received;
- When assessment of all information gathered indicates risks to patient safety: there is evidence of circumstances in the delivery of care which '*could have, or did lead to unintended and/or unnecessary harm*'.

In keeping with the management of an extreme, Category 1 incident, in such circumstances, a decision should be taken that a review is required under the HSE Incident Management Process.

This should be based on the guiding principle of an identified need for further learning to reduce risks and to improve patient safety at service and/or organisational level.

Steps following a decision to progress to incident review include:

- Agreement on approach to the incident review required;
- Agreement on level of independence, composition and/or membership of incident review team;
- Communicate this decision and rationale to the family/their relevant person(s) and staff involved in service user's care[12];
- Chair of the SIMT to assign a Service User Designated Person for the family/their relevant person(s) and a Staff Liaison Person to provide support during and after the review process;
- Communicate this decision and rationale to the local Community Mental Health Team;
- Record SIMT decision on the NIMS review screen.

11 In keeping with the principles of openness and transparency, those affected by the incident, including the bereaved family/their relevant person, are to be informed in a timely manner of the outcome of the SIMT's decision making and their rationale for further review or otherwise.

12 This communication process should be supported by the Designated Support Person and Staff Liaison Person

SIMT Decision: Review under alternative process

The SIMT's preliminary assessment may identify concerns that are more appropriately managed under a review/investigation process other than or in addition to the incident management process. For example, the complaints procedure or HR processes.

The HSE has a number of policies and procedures dealing with a range of issues requiring review/ investigation other than serious incidents. There is extensive guidance on these alternative review pathways available in the Incident Management Framework-Guidance.

Steps following a decision of review under alternative process include:

- Once the decision is final in accordance with local ratification procedures – the decision and rationale must be communicated to the family/their relevant person(s) and to the staff involved in service user's care, being mindful of confidentiality at all times;
- Communicate this decision and rationale to the local Community Mental Health Team;
- Record decision on NIMS review screen.

Documentation of SIMT Decisions

- All decisions of the SIMT should always be documented in **Part B and Part C of the Preliminary Assessment form**;
- There should be clear evidence documenting the reasons to support the decisions taken by the SIMT;
- The names and contact details of the Service User Designated Person and the Staff Liaison Person should be recorded on **Part C** of the preliminary assessment form.

NIMS Review Screen

- The decision of the SIMT should always be recorded on the **NIMS review screen** page;
- In cases where the decision is to only manage the incident under a pathway different to the Incident Management Framework, **the NIMS review screen** should be closed to indicate the closure of the incident management process.

Summary Step 4: Categorisation and Initial Assessment	
Key Actions	**Person(s) Responsible**
Seek assurance re initial contact, any concerns and support for Family/ their Relevant Person(s) and staff liaison person	SAO/Head of Service
Seek assurance re initial contact, any concerns and support for Staff involved in Service User's Care	SAO/Head of Service
Assign person to co-ordinate gathering of background information in preparation for review decision making meeting	SAO/Head of Service
Arrange for Serious Incident Management Team (SIMT) to meet	SAO/Head of Service
Document Part A of Preliminary Assessment Form to inform SIMT's decision making	Assigned Staff Member
SIMT meeting make informed decision regarding need for further management and/or review	Chair of SIMT
Documentation of SIMT Decisions in Part B and Part C of Preliminary Assessment Form	Chair of SIMT
Recording of SIMT Decisions on NIMS Review Screen	QPS Support
Communication of SIMT decisions to family/their relevant persons	Chair of SIMT or Designated Support Person
Communication of SIMT decisions to staff involved in care, including CMHT	Designated Staff Liaison Person/ Line Manager
Communication of SIMT decisions to QPS Committee	Chair of SIMT

IMF Step 5: Review and Analysis

Purpose of Incident Review

The purpose of undertaking an incident review is to better understand what happened and what learning can be made to minimise the risk of a similar event happening again. Incident reviews are focused on looking at factual information relating to care and service delivery leading up to the event. Incident reviews are not about trying to find out what caused the service user's death as this is the role of the Coroner.

Approaches to Incident Reviews

The Incident Management Framework outlines a full description of approaches to reviews. Guidance is included on the level of independence for a review along with additional supporting tools used when conducting a review. The following are suitable system analysis approaches when there is an incident relating to the death of a service user by suspected suicide.

Comprehensive System Analysis Review

When the SIMT make a decision that an incident review is required, the most common approach when there is a Category 1 incident involving the death of a service user is that of a comprehensive, system analysis review to ensure learning for the service.

- A comprehensive review should always be commissioned by the Senior Accountable Officer or a person directly accountable to the SAO.
- The Commissioner is responsible for establishing the terms of reference for the review and appointing the review team.
- The review team appointed should contain members who have relevant clinical expertise and relevant incident management expertise.

The Incident Management Framework advocates that all incidents are best assessed and managed as close to the service where the incident occurred to encourage ownership for learning.

However, it should be noted that a degree of independence is always required for an incident review. It should not be facilitated or led by a person who was directly involved in the care of the service user as this may introduce bias and represent either a real or perceived conflict of interest.

Aggregate Review

Aggregate reviews can be taken to analyse a group of incidents of suspected suicide that take place in the community setting over a specified time period and/or within an area. This would complement individual comprehsnive reviews undertaken.

- Both qualitative and quantitative methodologies can be used to assist in identifying trends or patterns that have the potential to contribute to learning and improving service user safety.
- Consideration can also be given to carrying out an aggregate analysis of preliminary assessments (including those where 'no further review' was undertaken) and review reports completed within a service/service area.
- The outcome of such an analysis can contribute to a greater understanding of the underlying care and service delivery issues identified in the assessments and review reports along with noted good practices.
- Aggregate reviews should be incorporated into the oversight work of Quality and Safety Committees on a regular basis.

Involvement of Family/their Relevant Person(s) and Staff in review process

- The inclusion of the family/their relevant persons and the staff involved in the service user's care is an integral part throughout the review process.
- When shared, their views and concerns should be taken into consideration.

The Designated Person assigned to support the family/their relevant person(s) and **the Staff Liaison Person assigned** to be the contact person for staff should be available, supportive and maintain open communication during and after the review. Their role also includes providing information and keeping them updated regarding the review process.

- **The families/their relevant person(s)** involvement in the review and the means of communication chosen by them should always be in accordance with their expressed wishes.
- They may also choose not to partake or may not be ready or feel able to contribute.
- **Staff members'** participation in a review process may involve writing their recollections of events at the time the service becomes aware of the service user's death, being interviewed individually and/or facilitated in a group with their team.

Open and Fair Review Process

While participating in an incident review, all who contribute to the review process can expect to:

- Participate in an open and fair process
- Always be given the terms of reference in advance of the review
- Have sight of the review report in draft format so that they can check to ensure that their views or any contribution that they have made have been represented fairly and accurately, before the report is finalised
- Be informed of the outcome of the review when it is finalised.

Principles of Openness and Transparency with the Family/their Relevant Person(s) and the Review Process

Open Disclosure involves open and transparent communication with those affected in the aftermath of a patient safety incident. Open Disclosure is part of the ongoing communication process with the bereaved family/their relevant person(s) in the aftermath of an adverse event.

- As with all communications between the service and the family/their relevant person(s), the timing and nature of the open disclosure communications should always take into consideration and have due regard to the grieving process.
- All communications should be sensitive to the wishes of the bereaved if and when they are able or ready to engage with the services.
- An expression of sympathy to the bereaved family/their relevant person(s) should be made on behalf of the service at the start of the engagement process.
- The findings of the review should be communicated to the family/their relevant person – ideally in person, but via other means if that is their preference. If any key causal factors were identified these should be explained fully and a meaningful apology made i.e. apology, in relation to an open disclosure of a patient safety incident, means an expression of sympathy or regret.

The principles of openness and transparency with all those affected by the death of a service user by suspected suicide have been included in each of the six steps outlined in this guidance document.

Incident Review Reports

When a system analysis approach to review is taken, the organisation's requirement is that it should be completed within a timeframe of 125 days starting from the date that the service is notified of the incident. The review team will produce a report documenting the chronology of events, the analysis of the factual information gathered, the statement of findings, if any and the factors which contributed to the incident. The report sets out any noted good practices and any recommendations for care and service improvement identified that are linked to the evidence in the report.

A system analysis **review report template** is available in word format along with a **quality assurance checklist** for completing a review report on the HSE Incident Management Website.

Governance and Approval Process for Review Reports

The SIMT play a central role in considering final draft review reports. Once an incident review report has been completed and quality assured, the SIMT make a recommendation to the Commissioner of the report to accept the report or not to accept it.

Refer to the HSE Incident Management Framework's guidance for more details on the governance and approval process for acceptance of review reports.

Update NIMS

The date that the review report is accepted by the commissioner should be recorded on the NIMS review screen. The completion of this field on the NIMS review screen is required to record closing the review process.

Supporting Information

Resources to support the Incident Management Framework include **staff and service user information leaflets** on what to expect during a review. They should be given to family/their relevant person(s) and staff and explained in advance of the review.

Both leaflets are available as part of the incident management resources which are available on the HSE website here.

The **HSE Open Disclosure Office** have developed a range of resources for both the public and for staff to learn more about Open Disclosure and for putting it into practice. Resources are available on the HSE Open Disclosure website here.

IMF Step 6: Improvement Planning and Monitoring

Learning Outcomes from Incident Reviews

Once a review report is accepted, it is the Commissioner's responsibility to ensure that an action plan to implement any recommendations made is developed.

The action plan should also include a communication plan to ensure all those who contributed to the review and/or were affected by the incident are made aware of the outcome of the review, its recommendations if any and the plans to put them into action.

It is the Commissioner's responsibility to manage access to the review report.

Feedback to Those Affected

In keeping with the principles of openness and transparency and the Open Disclosure Policy as applicable, the family/their relevant person(s) should always be offered:

- A meeting to discuss the findings of the review report. This meeting should include a relevant senior clinician to give feedback and to answer any questions arising.
- A copy of the report by the Commissioner, if they wish to receive one. This could be given in advance, during or after the meeting, in accordance with expressed preference.

Staff involved in the care of the service user and the Community Mental Health Team should likewise be given:

- A copy of the report from the Commissioner
- An opportunity to be informed and to discuss the findings of the review.

Quality and Safety Governance Committee Role

Pending the formation of revised QPS Committees in the six Health Regions, CHO and/or Mental Health Service's Quality and Safety Governance committees play a role in:

- Monitoring and overseeing the implementation of action plans arising from recommendations.
- Linking action plans arising with relevant service wide quality and service improvement plans.
- Using Data for Improvement
  - Oversight of aggregate reviews and analysis of incident review reports, recommendations and the actions arising to identify trends and patterns that contribute to patient safety learning.
  - Aggregated reviews can include incidents where 'no further review' was undertaken.
  - Monitoring aggregate NIMS data reports both over time periods and/or at service level of all incidents reported as suspected suicide within the community setting.

Sharing the Learning

Sharing the learning from incident reviews and data analysis involving suspected suicides that occur within the community setting should be fostered across local services and regions. Some examples of how this could be done include using learning notices or holding learning events.

Patient Safety Together

For further resources to support sharing learning, there is also the opportunity to utilise the HSE's 'Patient Safety Together' platform, which is the sharing of learning component of the Patient Safety Programme to support the implementation of the HSE Patient Safety Strategy. To learn more about 'Patient Safety Together', click here.

Part B Postvention Resources and Support

Postvention is a term often used in the suicide prevention field and refers to an organised response in the aftermath of a death by suicide.

Postvention responses can provide immediate and ongoing support to those impacted by the death of a service user by suspected suicide. Receiving timely, evidence based support can be effective when there is a risk to those bereaved of further suicide or self-harm. It can also promote caregiving and assist those affected through the process of grieving and loss.

B.1a Staff Support in the Aftermath of the Death of a Service User by Suspected Suicide

Staff are amongst those impacted by the suspected suicide death of one of their service users. Staff need to be given the opportunity for support. Line managers can provide direction to their staff on how to access information and support services, in the aftermath of such events.

Information regarding HSE staff support services in response to critical incidents, including bereavement counselling are outlined below:

Critical Incident Stress Management (CISM)

CISM Response helps staff who need support following a traumatic incident.

CISM is not counselling or psychotherapy. It is referred to as an emergency mental health intervention, which is a form of psychological first aid. It offers staff structured social support following a critical incident which aims to prevent harmful effects and provide staff with coping and self-management techniques to return to normal team working.

Further information and details are available here.

HSE Employee Assistance Programme – Staff Counselling

The HSE Employee Assistance Programme (EAP) is a work-based support service for staff and the organisation. The Programme offers counselling support for staff in the aftermath of a critical incident.

The service is a confidential, independent service which is free and available to all HSE employees.

Access to Online Staff Support Resources

The EAP site also contains access to information on a range of online resources that may be helpful for staff when deciding to proceed with counselling or while awaiting an appointment with a counsellor, available here.

B.1b HSE Open Disclosure Office – Staff Support Resources

The importance of support for staff from line managers, colleagues and peers in the aftermath of an adverse event or patient safety incident should not be underestimated. Staff require a safe and confidential space in which to discuss the event and can find this therapeutic. If a preliminary assessment indicates that the role of individual staff members requires assessment this must be conducted with regard to the HSE's Just Culture guidance which can be found here. This is a commitment of the HSE's Patient Safety Strategy which states "staff must be actively encouraged to speak up for safety, feel psychologically safe, be involved in decisions which affect the safe delivery of care and be provided with the skills, support and time to engage in patient safety improvement initiatives".

"ASSIST ME" Model of Staff Support

The Assist Me Guide has been developed by the HSE Open Disclosure Office and is available on their website. It provides practical information and guidance for managers and staff in relation to:

1. Understanding the potential impact of patient safety incidents on staff
2. Recognising and managing the associated signs and symptoms
3. Supporting staff following patient safety incidents
4. Providing information on the support services available to staff.

HSE Open Disclosure Office - List of Support Services and Resources following an Incident

The support services and resources listed in this document are those provided by or endorsed by the HSE and which may most likely be of assistance to staff following an incident, in particular a patient safety incident. These services and resources will provide additional guidance and support during the incident management and open disclosure process. The list is available on the HSE website here.

B.2 Suicide Bereavement Services and Resources

There are a range of practical resources written in plain language and designed with the user in mind that can be made available to all those impacted in the aftermath of a death of a service user by suspected suicide, including family members/their relevant persons. These resources can be found on the HSE Mental Health Service's website[13].

'You are not alone – Support for People who have been bereaved by Suicide' – the National Suicide Bereavement Support Guide

This guide is dedicated to those grieving the death by suicide of someone they love. It has been developed by a small group of people comprising of individuals who have lost loved ones through suicide and HSE Resource Officers working in the area of suicide prevention. The guide is also available from the National Office for Suicide Prevention, here.

13 Suicide bereavement resources: https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/resources/booklets/

It is not intended as a guide that one needs to read through from cover to cover. It focuses on five key areas:

1. Taking care of the practical matters
2. What you may be feeling
3. Your connection with the person who has died
4. Getting through and creating a new future
5. Help and support.

If you have been bereaved by suicide

This guide offers advice and guidance to help the reader understand the range of emotions and physical reactions people experience when first discovering that someone close has died by suicide. It has three parts:

1. The grieving process.
2. What is different about suicide?
3. The need to understand.

Supporting someone bereaved by suicide

This guide offers advice and guidance on how best to support someone who has been bereaved by suicide. It has two parts:

1. Supporting those bereaved by suicide
2. Self-care.

Supporting children and young people bereaved by suicide

This guide offers advice and guidance on how best to support children and young people bereaved by suicide. It has four parts:

1. Talking to your child about suicide
2. Answering difficult questions
3. How children and young people may respond to a death by suicide
4. How to support children and young people, depending on their age.

B.3 Suicide Bereavement Liaison Service

The Suicide Bereavement Liaison Service is a free, confidential service that provides assistance and support to families and individuals after the loss of a loved one to suicide. The service is provided by different agencies around the country, funded by the HSE National Office for Suicide Prevention.

The Liaison Officer can meet with a bereaved family as a group or individually. They can answer questions about some of the difficult practical issues following a death by suicide. They also provide guidance or assistance in accessing a therapeutic service, or even just to talk with someone locally about what has happened.

The service is available countrywide with contact details listed on the website of the National Office for Suicide Prevention here.

B.4 Resource Officer for Suicide Prevention (ROSP) – Postvention Role

HSE Resource Officers for Suicide Prevention (ROSP) have a role in providing postvention information and support to people and communities impacted by suicide. The ROSP is an integral resource person for the development and activation of Community Response Plans (see '*Developing a Community Response to Suicide' below*). As per local arrangements, the Head of Service, Mental Health or a nominated staff member should link with the ROSP in relation to their involvement in postvention community responses when the suspected suicide is that of a community mental health service user.

The role of the ROSP is not limited to postvention. An overall description of the ROSP role and their broader responsibilities in relation to suicide prevention can be found in Appendix 3.

B.5 Cultural Awareness

Intercultural Awareness eLearning programme, available on www.hseland.ie.

This eLearning programme supports staff to be aware and respectful of the ethnic, cultural and religious diversity of people who use our services. The main aim of this programme is to reduce the potential harm that unconscious bias may cause.

A Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings

This Guide was developed in response to an expressed need by healthcare staff across a range of cultural backgrounds for knowledge, skills and awareness in delivering care to people from backgrounds other than their own. The guide profiles the religious and cultural needs of twenty-five diverse groups who are being cared for in healthcare settings.

Multilingual Resources and Translated Information

The '**Multilingual Aid**' aims to help health staff to communicate more effectively with service users and their families when English is not their first language. It contains translations from English to over twenty other languages for basic introductory and health related information. It is intended for use prior to asking for the services of an interpreter or while waiting for the interpreter to arrive.

Good practice guidelines for HSE staff on working with interpreters

An interpreter is a person who speaks more than one language and can help to communicate with services users and families in their first language. The HSE provides guidelines for healthcare professionals to support good practice in the provision of interpreting services.

These resources are provided by HSE National Social Inclusion Office. Further information and updates to training and resources can be found here.

B.6 Developing a Community Response to Suicide

In 2021 the HSE National Office for Suicide Prevention published 'Developing a Community Response to Suicide', which provides guidance to improve health-led readiness and planning for incidents of suspected suicide which may impact a community.

This operational guidance is intended to support the development of a Community Response Plan (CRP) in each HSE Community Healthcare Organisation, CHO, particularly where there is an emerging risk of clusters and/or suicide contagion of incidents of suspected suicide. This, along with all HSE PPPGs will in time reflect the six health regions rather than CHOs.

While other related plans (for example, psychosocial responses) may already be in place, this resource supports the development of a CRP specifically for cases/clusters of suspected suicide(s). The guidance can be used as a practical resource for those involved in the preparation, writing, implementation and review of a new or existing plan.

The guidance emphasises the importance of multi-agency and collaborative working in this area. The CHO Community Mental Health Services including the Resource Officer for Suicide Prevention (ROSP) are a part of this collaboration.

The guidance provides information on how appropriate teams, roles, responsibilities and systems should be established. It gives clear criteria for how and when a CRP should be activated and deactivated, and guidance on how it can be evaluated and reviewed. The CRP Lead will be a senior HSE manager. The main aims of the CRP guidance are to ensure:

- Preparedness - which is key to ensuring a successful response to incidents of suspected suicide
- Foremost involvement and engagement with individuals or communities who have been bereaved by suspected suicide
- Early detection of potentially related suicides
- A timely and coordinated response amongst a number of agencies
- Commitment to serving the expressed needs of the community and building on the community's own strengths
- Robust links to existing appropriate services, supports and information sources
- Commitment to ongoing learning and the review and improvement of all practices.

The HSE National Office for Suicide Prevention (NOSP) worked with multiple partners to develop this guidance, and is committed to supporting areas in developing their own community response plans.

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Irish Statute Book, Office of the Attorney General, *Civil Liability (Amendment) Act 2017.*

Mental Health Commission 2020. *Guidance on Quality and Safety Notifications.*

National Treasury Management Agency (Amendment) Act. 2000.

US National Guidelines 2015. *Responding to Grief, Trauma and Distress after a Suicide.*

Appendix 1

Working Group Membership

- **HSE Access and Integration**
  - Dr JP Nolan, Assistant National Director Access and Integration (Co-Chair)
  - Áine Clyne, Quality and Safety Manager (Project Lead)
  - Eimhin Cullen, Data Manager
  - Heather Kelly, (Secretariat)
  - Derek Chambers, General Manager, Mental Health Operations
  - Martin Ryan, Suicide Prevention Resource Officer
- **HSE Regional Health Areas**
  - Karl Brogan, Head of Service, QSSI, HSE West and North West
  - Kevin Brady, Head of Service, Mental Health, HSE Dublin and Midlands
  - Dr Mia McLaughlin, Clinical Director, HSE Dublin and South East
  - Cormac Walsh, Area Director of Nursing Mental Health, HSE Dublin and South East
- **HSE National Quality and Patient Safety Directorate, Incident Management Team**
  - Loretta Jenkins, General Manager
- **HSE National Office for Suicide Prevention**
  - Prof Philip Dodd, Clinical Advisor (Co-Chair)
- **College of General Practitioners**
  - Dr Brian Osbourne, General Practitioner

Appendix 2

Preliminary Assessment Form for Incidents of Suspected Suicide within Community Mental Health Settings

Part A

To be completed in advance of the SIMT/Review decision making meeting.

Prompt questions included to guide gathering of information, as relevant.

A.1 Incident Details	
NIMS Reference No:	
Date entered on NIMS:	
Date of Incident:	
Date service became aware of incident:	
Date Notified to SAO:	
Date of SIMT/Review decision meeting:	
Date Report Completed:	

A.2 Service User's Background & Chronology	
Background information about the service user including their history, diagnosis, and chronology of engagements with the Community Mental Health Team up to their death	
Chronology and known details regarding the circumstances of the service users death?	
Did the service user actively attend the community mental health service?	
• Were they engaged with therapy/specific interventions?	
• Recent discharge from Acute Care or an Emergency Department? • If yes, give date	
When was the service user last seen by a member of the CMHT? – or any other Mental Health Service, please specify.	
• Brief outline of the service user's mental state on last CMHT review	

A.2 Service User's Background & Chronology	
Considerations about Risk Management and Care Planning	
• Were any risk issues identified at last review? e.g. suicidal ideation, thoughts of self-harm etc)	
• Was the plan of care appropriate to the service user's mental state?	
• Was there a history of self harm/attempted suicide/suicidal ideation? (include dates)	
• If yes; was there an up to-date plan of care in place in response?	
Considerations about Medication Management	
• Was there a recent review of medication?	
• Was medication recently changed? • If yes, what was the change?	
• Are there any concerns regarding the prescription provided to the service user at last review?	
• Were there concerns re service user's medication management?	
Were there recent gaps of attendance at outpatient or therapy appointments e.g. DNAs or delayed access?	
• If yes, was there a requirement for these to be followed up? • How were they followed up?	
Communications with service user	
• Is there evidence of communications between the service user and the CMHT, in time leading up to death? • If yes, state type of communication?	
• Were there any modes of communication missed? e.g. letters, phone messages, emails unanswered	

A.2 Service User's Background & Chronology	
Other services involved in service user's care	
• Was the service user attending any other services?	
• Did they have shared key workers/links with other services?	
• Have the other services been informed of the service user's death?	
What contact has the service had with the service user's family/their relevant person(s)?	
• Were the family/their relevant person(s) involved in the service user's plan of care?	
• Have the family/their relevant persons been contacted? If not, please outline why this has not been completed. • Have they raised any issues for consideration by CMHT?	
Issues for consideration expressed by family/their relevant person(s)?	
Issues for consideration expressed by staff?	
Any other relevant information?	

A.3 Assurance Checklist: Actions taken to date	
Any immediate actions required to prevent harm to others as a consequence of the unexpected service user's death have been identified. • Family/their relevant person(s) • Staff • Other service users • Environmental	
The immediate supports needs of persons affected is in place • Family/their Relevant Person(s) • Staff involved in service user's care • Others	
Communications	
• All members of Community Mental Health Team (CMHT) informed of service user's death?	
• Contact made with service user's family/their relevant person(s)?	
• Other services/staff involved in care of service user informed?	
All communications initiated in accordance with the principles of the Openness and transparency or/explanation if communication has not yet been possible.	
Service User Designated Support Person and Staff Liaison Person in place Yes ☐ No ☐	
Documentation in clinical file	
• The occurrence of the suspected suicide, any actions taken or relevant information	
• All meetings, communications or actions taken with the family/their relevant person(s)	

A.3 Assurance Checklist: Actions taken to date	
Incident Reporting completed • NIMS • Mental Health Commission • Other external bodies/agencies	
Name and Title of Person completing Part A	
Date of completion	

Part B – Record of Decision

To be completed at the SIMT/or review decision making meeting

B.1 Management of Incident to date

Based on Part A and discussions at the meeting include here an assessment of the adequacy of actions taken or planned in relation to the incident. Include also details of any further actions required.

B.2 Appropriate Pathway for Review of Incident Reported

Having considered Part A is the SIMT/Review decision making meeting satisfied that the Incident Management Framework is the appropriate pathway for the management of this issue?

Yes ☐ No ☐

If No, please indicate which alternative review/investigation route is most appropriate. (See making decisions about appropriate reviews/investigations pathways guidance – IMF Guidance Section 3)

If Yes, AND it is also decided appropriate to also conduct a review/investigation using an alternative pathway, please document below the alternative pathway and recommendation in relation to scheduling of the two processes.

B.3 Information required for decision making in relation to review under the IMF

Is further information required to assist a decision to review? Please select one option below:

Yes ☐ No ☐

If Yes, please indicate the type of information required

Healthcare Record Review ☐

Other Specify:

B.4 Approach to review

Please indicate the decision as to the approach of review to be conducted. Please select one option below:

Comprehensive Review	☐	If Comprehensive Review is selected, proceed to Part C.
Concise Review	☐	If Concise Review is selected, proceed to Part C.
No further Review	☐	If No Further Review selected, complete Section B.5 and refer to relevant Quality and Safety Committee for completion of B.6.

B.5 Sign off of decisions where No Further Review Required

If the decision is NOT to commission a Comprehensive Review or Concise Review, please set out below the reason or rationale for this decision and the evidence upon which it was based.

Reason:

B.5 Sign off of decisions where No Further Review Required
Please outline below, any learning opportunities identified along with the arrangements required to ensure that these inform relevant care or management practice.
Date:

For Category 1 Incidents Senior Accountable Officer (SAO) Details
Name:
Signature:
Date:

Decisions where no further review required must be:

- Submitted for review and ratification by the relevant Quality and Safety Committee or other equivalent committee.
- Communicated to persons affected i.e. service user, relevant person(s) and staff.
- Entered onto NIMS and this should include the reason and rationale for same.

These incidents should be incidents in an Aggregate Review process.

B.6 No Further Review Required – Ratification of Decision
Ratified by Quality and Safety Committee or equivalent committee Please select one option below: Yes ☐ No ☐
If No is chosen please outline the reason for this below and submit this form to the SAO **Reason:**
Date:

Part C – For Incidents where a decision to review the incident has been taken

Please complete this section

C.1 Comprehensive Review

A decision has been taken to commission a Comprehensive Review

Yes ☐ No ☐

Note: The Final Report of the Comprehensive Review must be accepted by the Review Commissioner within 125 days of date notified of the incident.

Note: Category 1 incidents require a comprehensive review

C.2 Concise Review

A decision has been taken to commission a Concise Review

Yes ☐ No ☐

If the decision is to commission a Concise Review, indicate whether this will be by way of any option below.
Please select one below:

Multidisciplinary Team Approach
(Tick appropriate box for methodology to be used)

Systems Analysis	☐
After Action Review	☐
Incident Specific Review Tool	☐
Desktop Review	☐

The Final Report of the Concise Review must be accepted by the Review Commissioner within 125 days of Date notified of the incident.

C.3 Level of Independence attaching to the review

Please select one option below

1. Membership of Team internal to the team/department/NAS Operational Region ☐
2. Membership of Team internal to the service/hospital/NAS Operational Area ☐
3. Membership of Team external to the service/hospital but internal to the CHO/HG/NAS Corporate Area ☐
4. Membership of Team involve persons external to the CHO/HG/NAS Directorate ☐

C.4 Scope of the Review

This should set out the timeframe to be reviewed e.g., from admission to incident occurrence, from referral to incident, from X date to Y date.

C.5 Composition of the Review Team

Whilst it is not necessary to identify by name members of the Review Team at this stage the composition by title/profession should be listed.

C.6 Contacts in relation to the review process

Review Commissioner (SAO – Category 1 Incidents)
Name:
Email:
Telephone:
Service User Designated Support Person
Name:
Email:
Telephone:
Staff Liaison Person
Name:
Email:
Telephone:

Appendix 3

Resource Officer for Suicide Prevention

The HSE Resource Officers for Suicide Prevention (ROSP) work across the nine Community Health Organisations (CHOs). The role of the ROSP within HSE Mental Health is complex, uniquely skilled and multi-faceted. The roles can vary across Community Health Organisation (CHO) areas depending on a number of factors. Areas differ in terms of demographics, priority groups, services available, rates of suicide and self-harm and internal HSE structures, to name but a few. The role includes the following core areas of work:

Prevention

The ROSP works closely with HSE Mental Health Services; other HSE Care Groups; The National Office for Suicide Prevention; other State Agencies; the Non-Governmental Organisation (NGO) sector and partners in the community and voluntary sector to implement *Connecting for Life, Ireland's National Strategy to Reduce Suicide* at CHO level. The ROSP is the designated lead for the development and implementation of local or regional *Connecting for Life* Action Plans.

In relation to prevention, each ROSP coordinates the delivery of suicide prevention training to a broad range of audiences in the CHO. The programmes are of high quality and evidence based and include safeTALK, ASIST, Understanding Self-Harm and Suicide Bereavement training. For more information see www.nosp.ie/training.

Intervention

The ROSP is a point of contact in the CHO for information and support relating to mental health and suicide prevention. Responsibilities here include the development and dissemination of local, regional and national initiatives and campaigns related to mental health, suicide prevention, stigma reduction and suicide bereavement support. Signposting to services is a significant element of the work as is highlighting gaps in supports and advocating for improvement in service delivery.

The ROSP works within a broad range of networks to ensure that suicide prevention is on the agenda for anyone working in mental health related areas and in particular with priority groups. The ROSP ensures that people impacted by suicide are included in all aspects of their work.

Postvention

The ROSP also has a role in providing postvention information and support to people who have lost a loved one to suicide. This includes supporting other organisations, families and communities by signposting or by providing direct community responses to those that are affected. The role of the ROSP is an integral resource in the development and activation of Community Response Plans in communities when suicide clusters emerge or where there is risk of suicide contagion.

Contact Details

Contact details for the Resource Officers for Suicide Prevention can be found on the website of the National Office for Suicide Prevention by clicking here.

Health Service Executive
Dr Steevens' Hospital
Steeven's Lane
Dublin 8
D08 W2A8