West London Mental Health NHS Trust

We care to make the difference

Policy: D6

Death of a Patient

Version:	D6/05 Feb11
Ratified by:	Policy Review Group
Date ratified:	17th August 2010
Title of originator/author:	Broadmoor SMT
Title of responsible Director	Director High Secure Services
Date issued:	19th February 2011
Review date:	August 2012
Target audience:	**All staff Trust wide**

West London Mental Health NHS Trust

We care to make the difference

POLICY TITLE	Death of a Patient
POLICY REFERENCE NUMBER	D6
DATE OF IMPLEMENTATION	19th February 2011
DEVELOPED / REVIEWED BY	Director of High Secure Serrvices and Director of Nursing & Patient Experience
DUE FOR NEXT REVIEW	August 2012
RESPONSIBLE DIRECTOR	Director of High Secure Serrvices and Director of Nursing & Patient Experience
DISCLOSURE STATUS	(B) Can be disclosed to patients and the public

Equality & Diversity statement

The Trust strives to ensure it's policies are accessible, appropriate and inclusive for all. Therefore all policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed

The Trust aspires to:

Policy D6
Death of a Patient

Version Control Sheet

Version	Date	Title of Author	Status	Comment
D6/01	25.08.06	Director of Nursing	N/A	New Policy developed and approved by the Trust wide Clinical Research Governance Executive Group (TCRG)
D6/02	Feb 09	Director of High Secure Services & Nursing	Policy reviewed	As a result of staff change in dept the Policy reviewed - no changes made and review date extended to Aug 09
D6/03	28.08.09	Director of High Secure Services and Director of Nursing & Patient Experience	Revised Policy issued	Review of Policy undertaken and endorsed at June 09 CSSG following approval of additional paragraphs at 1.5 and 1.6 and Appendix A on Child Death Reviews and Serious Case Reviews
D6/04	27th August 2010	Director of High Secure Services and Director of Nursing & Patient Experience	Revised Policy issued	Following April Trust Board Dir of HSS tasked with chasing the outstanding actions. An additional paragraph in section 4.4 – Patient's Property added. Revised policy out for consultation period ending 4th June 2010 Policy tabled at 17th August Policy Review Group - approved.
D6/05	11th February 2011	Assistant Director of Primary Care	Revised Policy issued	Following advice from London MCA Lead Policy changed (point 1.3) to reflect death of a patient subject DoLs is to be treated as a death in custody.

D6
DEATH OF A PATIENT

INDEX

1 INTRODUCTION

1.1 In the sad event of a patient dying, (s)he will be accorded the respect and dignity required at this sensitive time. Consideration will be given to the patient's spiritual, cultural and religious wishes, and to any special requests made by the patient and/or their family.

1.2 In the event of a death, local procedure sheets should be used as *guidance* and should be completed only in so far as the action is appropriate. When a patient is known to be suffering from a terminal illness the clinical team must develop a care plan to cover issues that will arise at time of death and thereafter.

1.3 The death of a detained patient **including those detained under the Deprivation of Liberty Safeguards (DOLS)** is regarded as a 'death in custody' (wherever this happens) by the coroner and the Police must always be notified on such occasions and details of who to be contacted must be contained in the site-specific procedure sheets

1.4 In the case of all deaths, the service user's nearest relative and person with whom they had closest contact should be informed as soon as possible after verification of death.

1.5 Child Death Reviews[1] (death of a child)

The Children Act 2004 introduced a new responsibility for Local Safeguarding Children Boards (LSCB) to undertake a review of the circumstances surrounding the death of any child in their area. The requirement for Child Death Reviews is set out in Chapter 7 of Working Together. This requirement applies to all child deaths and not just those that may be linked with non-accidental injury.

Where a child dies who is known to the Trust, a notification must be sent to the local designated Paediatrician responsible for unexpected deaths in childhood. A Trust Incident report will be completed in al such cases. Each LSCB is required to have a Child Death Overview Panel (CDOP) and this Panel will lead the review process and call on individual agencies to contribute as appropriate. The DCEO will decide if the circumstances and involvement of the Trust warrants the commissioning of a Serious Adverse Incident Review (in accordance with the Incident Reporting & Management Policy I8). **Appendix A** sets out the requirements and the process to be followed but still within the framework of the Trust's Incident Reporting and Management Policy.

1 Working Together HM Gov 2006 – Chapter 7 – Child Death Review Process

The London Rapid Response Procedure should be followed when a decision has been made that a death of a child is unexpected; or there is a lack of clarity about whether a death of a child is unexpected. Advice should be sought in these circumstances from the relevant Executive Director and Named Doctor for Safeguarding Children in conjunction with the local safeguarding children team.

1.6 Serious Case Reviews[2] (death or serious injury of a child as a result of non-accidental injury) – See Appendix B
Where a child dies or is seriously injured as a result of non-accidental injury, the Local Safeguarding Children Board (LSCB) for the local authority area in which the incident occurs will convene a Serious Case Review in accordance with the guidance set out in Chapter 8 of Working Together. Each agency involved will be asked to undertake an Internal Management Review (IMR) as a contribution to the Overview report prepared by the LSCB. IMRs will be undertaken by the Trust within the framework of this policy and Appendix D sets out the process for meting this requirement

Immediate action should be taken to safeguard a child who has been injured or where other children may be at risk. The case records relating to the child should also be secured and passed to the SDU Director.

No investigation of the incident should occur at that time other than to:

- Act to protect the child or other children
- Ascertain the basic facts as relayed by those who may have observed the incident
- Advise the relevant senior manager and clinician for the service
- Advise the police and or Local authority Children's services Department who have the statutory responsibility to lead any child protection investigation together with the police.

2 SUPPORT

2.1 Informing & Supporting Patients

2.1.1 Immediately after the death of a patient, the staff available should decide on the most appropriate method of breaking the news to other patients (taking into account such issues as the time of day/night the death occurred and whether other patients are aware of it etc). This should be carried out as soon as possible and with adequate staff in attendance. This should be in discussion with other members of the Clinical Team/on-call personnel. Patients can exhibit a wide range of emotional response to such news and it is not unusual for such emotionally charged situations to result in conflict between patients or patients and staff.

2.1.2 It is advised that a ward community meeting, involving all patients and staff, should take place within the first 24 hours following a death. All patients' questions surrounding the nature and circumstances of the death should be answered truthfully and information only withheld if it is necessary to do so due to the legal process or matters of patient confidentiality.

---

2 Working Together HM Gov 2006 Chapter 8 – Serious Case reviews

2.2 Supporting Staff

2.2.1 Following the death of a patient, whether expected or sudden, staff who have been involved in their care should be supported by the local manager. Many feelings associated with bereavement can be experienced, and these may themselves be complicated by the circumstances.

2.2.2 Staff should have access to the appropriate individual or group support as determined by local circumstance.

2.2.3 Specifically staff should be made aware that they can access their local Occupational Health or Staff Counselling and Support Services, Spiritual and Pastoral care for individual or group support.

2.3 Informing and supporting relatives

2.3.1 It is very important that adequate support is offered to those affected by the death.

2.3.2 The doctor who is present at the incident (e.g. the Consultant Psychiatrist, the Duty Consultant or Duty Psychiatrist) is responsible for informing the patient's relatives/carers of what has happened. **This must be done promptly.** If another member of the multi-disciplinary team, who is well known to the relatives/carers, is present, the Consultant may delegate this responsibility to them, recording this in the patient's notes. The relatives/carers must be given the name and contact details of someone who can answer any further questions or concerns they might have after the initial contact. The central contact number for Special & Forensic CSU and Local Services CSU is 0208 354 8354. The central contact number for Broadmoor is 01344 754678.

2.3.3 Suitable arrangements may be required to provide support to relatives, carers or friends of the individual patient concerned.

2.3.4 The Director of Public Relations & Communications will ensure that the patient's relatives/carers have been informed of a death before any consideration is given to responding to questions from the media, unless the circumstances make immediate comment imperative.

3 MANAGEMENT RESPONSIBILITIES

3.1 Following the immediate actions at the time of death, which include actions by members of the clinical team and duty staff, the responsibility thereafter for ensuring completion of procedures and dealing with issues arising from the patient's death, rests with local managers and members of the Clinical Team

3.2 The Clinical Team must identify the patient's network of friends and those staff members who may not be members of the Clinical Team but who worked with the patient (e.g. creative therapist / psychologist / occupational therapist / social worker) and ensure that they are informed quickly and appropriately of the patient's death.

3.3 For an unexpected death the Consultant in consultation with the ward's Clinical Nurse/Ward Manager will arrange a post-incident meeting as soon as possible for the full Clinical Team and any other staff involved at the time of the death (e.g. staff responding from other areas, Chaplain, on call managers etc). This meeting must not be confused with other types of post incident meetings designed to offer support and stress debriefing for staff. Its purpose is to be a fact finding clinical review of the circumstances of the death. The Clinical Team will also consider whether there are any immediate lessons to be learnt and/or shared and will allocate responsibilities for this to appropriate Clinical Team members.

3.4 Managers should contact the local staff counselling and support service as soon as possible to make arrangements for critical incident stress debriefing. This will usually be facilitated between 3-14 days post incident.

3.5 The members of the Clinical Team must identify an appropriate person to co-ordinate and maintain contact with the patient's relatives and ensure that they are given support from the time the death occurs until the funeral and to continue offering support at least until the date of an inquest. Social Workers will often be the point of contact for patient's relatives.

3.6 Following an untoward incident that leads to a patient's death, the Chief Executive may appoint an appropriate level of inquiry and specify the terms of reference under the Trust's Serious Untoward Incident Policy.

3.7 Relevant action must be taken in relation to all formats of the health record (see H8 health records).

4 THE PATIENT'S PROPERTY

4.1 Following the death of a patient the Mental Health Act Office/Health Records or Patients services Department will establish whether the Finance Office or patient's legal representative is holding a Will that can be opened by hospital personnel in accordance with hospital procedure.

4.2 The disposal of the patient's property may be a sensitive issue for relatives and should be discussed by the Clinical Team (refer to Financial Procedures, Section 17)

4.3 When a patient states that he/she wishes a named person to be next of kin, this should be recorded in writing by the patient and witnessed by a member of staff. This information should be sent to the Mental Health Act Office or Patient Services Department. A clearly documented decision, particularly when a change has been made, will prevent conflict between relatives/carers after a patient's death.

4.4 When a patient is deceased the confidential legal documents form part of the patient's estate and should be subject to consultation with the patient's legal adviser and where necessary the Trust's legal advisor. Papers concerning criminal proceedings are confidential but most criminal proceedings will cease with the patient's death. In circumstances where such papers include data in respect of identifiable living individuals, who retain the protection of the DPA, and / or there may be unforeseen legal complications from disclosure such

papers should be sent back to the patient's solicitor. As an Officer of the Court the solicitor will be able to decide about disposing of the papers and acting on this.

5 REQUIREMENTS FOR PEOPLE OF DIFFERENT RELIGIOUS FAITHS

5.1 All staff are reminded that patients/service–users of the Trust come from a wide range of religious, cultural and ethnic backgrounds and that individual spiritual needs should always be considered in care planning.

5.2 In the event of a patient's death, information packs with regard to the traditions and procedures of different religious groups are available in all sites where care is delivered. Staff are encouraged to contact the Spiritual and Pastoral Care staff for further advice and support when necessary.

5.3 See section 7.2 for further guidance.

6 NOTIFICATION OF OTHER PROFESSIONALS

6.1 The Mental Health Act Office /Health Records Manager or Patient Services Manager must be notified as soon as possible. Local procedures will identify responsibility.

6.2 Informing other professional staff related to the patients care (ref: Care Programme Approach) will be carried out as soon as is practicable.

7 SITE SPECIFIC PROCEDURES

7.1 Managers of different sites within the Trust are responsible for developing local procedures to cover the action to be taken in the event of the death of a patient. Where applicable, these procedures should cover actions to be taken for detained or informal patients, whether in-patients, on leave of absence or in the community at the time of death; notification of relatives and involvement of other agencies. They should also describe the notification of deaths to the coroner's office and police involvement (with particular reference to detained persons). Once completed these procedures will be agreed through the Divisional clinical governance groups.

7.2 In developing site specific procedures local managers must use The Royal Marsden Hospital Manual of Clinical Nursing Procedures (5th Edition) Chapter 21 Last Offices; to inform procedural guidelines for last offices and the requirements for people of different faiths.

7.3 The Royal Marsden Hospital Manual of Clinical Nursing Procedures can be found in the Novell delivered applications folder.

Appendix A

CHILD DEATH REVIEW PROCESS

1. INTRODUCTION

1.1. The Children Act 2004 s.11 introduced a new responsibility placed on Local Safeguarding Children Boards (LSCB) [3]to have procedures to investigate and take an overview of all unexpected[4] child deaths in their areas. The overall purpose of the child death review process is to understand why children die and put in place interventions to protect other children and prevent future deaths. It is intended that these processes will [5]:

- Document and try to understand the cause of death so that parents can come to terms with the death of their child, and then take steps to prevent the deaths of any other children.
- Identify patterns of deaths in a community so that preventable or avoidable hazards that may contribute to deaths can be recognised and reduced.
- Contribute to the improved collection of forensic evidence in the very small proportion of deaths where there might be concerns of maltreatment or some other criminal act.

1.2. The LSCBs are required to be able to provide :

a) A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.[6]

b) An overview of all child deaths (under 18 years) in the LSCB area(s), undertaken by a panel. [7]

1.3. Each LSCB is therefore required to establish a Child Death Overview Panel (CDOP) as one of its sub committees to deliver these functions.

1.4. WLMHT links with 5 LSCBs for Ealing, Hammersmith & Fulham, Hounslow, Richmond and Bracknell Forest and each has established a CDOP but, as these functions are wide-ranging, each has chosen to make these arrangements in partnership with one or more LSCBs:

- Ealing LSCB in partnership with the LSCB for Hillingdon
- Hounslow LSCB in partnership with Richmond and Merton LSCBs
- Hammersmith & Fulham with Kensington & Chelsea and Westminster LSCBs
- Bracknell Forest with ????

1.5. It Is the responsibility of all NHS employees to comply with the Child Death responsibilities as undertaken by the LSCBs with which the Trust is linked.

1.6. WLMHT services are located in each of these boroughs and could, therefore, be involved in a review where the death of a child occurs unexpectedly.

---

3 Safeguarding Children Board Functions Regulation 6

4 'Unexpected' *the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death – Flemming et al 2000 RCPCH*) Taken from SHA London FAQ sheet

5 Royal College of Paediatrics and Child Health guidance on Child Death Review Processes March 2008

6 see paras 7.18–7.49 Working Together, HMG 2006

7 see paras 7.50–7.56 Working Together, HMG 2006

This might be indirectly though the involvement of a service with an adult member of a family or directly through services with a direct inpatient responsibilities for children e.g. the Wells and Cassel Service or in the community via CAMHS.

1.7. In some instances, the nature of the initial investigation of the circumstances of the child's death will prompt a decision to undertake a Serious Case Review i.e. where the cause of death relates to non-accidental injury.

1.8. In 2004 there were 4,706[8] unexpected child deaths across the age range from birth to 18th birthday which suggest, on average across the 152 PCTs in England, there are about 31 such deaths a year.

2. THE CHILD DEATH REVIEW PROCESS

2.1. Information about each and every child and the circumstances of their death is collected and summarised from records held by Ambulance Services, Hospitals, Community Health Services, schools, Police, Children's Services and other agencies whose staff knew the child.

2.2. A CDR Panel of doctors, other health specialists and child care professionals consider the information to try to ascertain what caused the child's death, what, if any, support and treatment was offered to the child and their family up until the death, and what support was offered to the family after the child died.

2.3. The CDR Panel decides whether recommendations and actions are needed to help prevent child deaths in the future. These are shared with local Health Trusts, Public Health Departments, Children's Services and the Police, as well as specialist agencies such as the fire service or traffic authorities in order to influence and improve services and life chances for children and families.

2.4. When a child death is sudden and unexpected, it may trigger an action at the time of death, similar to the established SUDI response (sudden unexpected death of an infant). This very rapid response may involve an immediate home visit, or a planned visit to the site of death within a day or so. A rapid response may also be triggered in the event of a fatal accident including some road traffic incidents

3. THE RESPONSIBILITIES OF WLMHT STAFF

3.1. When a child death occurs in any setting, any staff involved in the death of a child must notify:

- the senior clinician and manager for their service.
- The Trust Named Doctor
- The Service Delivery Unit Director and Clinical Director (or on-call Director if out of hours)

3.2. The local manager must also notify the Single Point of Contact (SPOC) for their local PCT (the up-to-date contact details can be found on the London SCB website:

http://www.londonscb.gov.uk/child_death/spoc/

(right click on this web address to go directly to this page and scroll down to the relevant PCT)

8 see para 7.9 Working Together, HMG 2006

3.3. This must then be followed up in writing on the pan London CDR Notification Form (see attachment A). (For Broadmoor – see Bracknell Forest ……??

3.4. Staff must cooperate fully in the process, and be prepared to submit medical notes and attend post death meetings if invited. Part of the Child Death review meeting will address the needs of staff that may be traumatised by the event.

3.5. Staff working in locations likely to be involved with child death, should be familiar with these the local protocols and procedures, particularly the details of the Single Point of Contact (SPOC).

NB it is not necessary to seek consent form a parent/carer when providing information to the SPOC or CDR as this is a statutory function. These issues will be managed by the professional staff responsible for the CDR. Subsequent reports are anonymised following initial notification[9].

9 Guidance issued by SHA London April 2008

Attachment: A

Notification to the designated paediatrician for unexpected deaths in childhood and the LSCB of a child's death

1. What is required?

1.1. Section 7.51 (WT) states that the LSCB should be informed of all deaths of children normally resident in the LSCB's geographical area. The designated paediatrician for unexpected deaths in childhood (or delegate) will usually do this and should be notified of all child deaths in the area or of children usually resident in the LSCB area but who die in another area.

1.2. Local agencies responding to a child's death as well as informing the coroner, if needed, should inform the designated paediatrician for unexpected deaths in childhood (or delegate) for the LSCB area using the attached proforma taken from the London SCB website.
http://www.londonscb.gov.uk/files/resources/cdop/child_death_notification_form.doc

1.3. Information can be conveyed in a confidential telephone conversation but there should be agreement during this call as to who will take responsibility for completing the attached written notification proforma. Where the information is passed by telephone it will be helpful for both parties to have a copy of the proforma in front of them while talking to assist the sharing of information.

2. The information should be treated in strictest confidence.

2.1. The written Notification proforma should be completed as fully as possible and sent the same day. For deaths which occur after 5pm, at weekends or on bank holidays, the written Notification proforma should be sent by 10am the next working day.

2.2. Parental consent is not required for this information to be passed to the designated paediatrician / Local Safeguarding Children Board. It should only be shared with those who need to know as governed by the Caldicott Principles, the *Data Protection Act* and *Working Together 2006*. Persons with parental responsibility *(Children Act 1989)* should be advised that the child's death will be subject to a review in order to learn any lessons tat may help to prevent future deaths of children. This must be handled sensitively. There is a LSCB leaflet available to assist parents and others with parental responsibility in understanding the review process and how they can contribute (see www.londonscb.gov.uk/child_death/. This would normally be done by the paediatrician confirming the child's death to the parents.

2.3. A death that is unexpected[10] may require a **rapid response** or a specific review of circumstances or an unexpected child death meeting as set out in the *London Child Protection Procedures section 12* [11]. It will be the responsibility of the designated paediatrician for unexpected deaths in childhood (or delegate) and senior police officer in the case to agree the process that such a response will take. This may involve LA children's social care or other agencies as needed.

---

[10] ' … defined as a death of a child (birth to 18 years, excluding babies stillborn) which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'. London Child protection Procedures 2007 Section 12.1.1

[11] ***London Child Protection Procedures*** – every agency must ensure that staff have access to a copy – they can also be accessed at www.londonscb.gov.uk/procedures

Initial notification of the death of a child – to be completed as fully as possible within the hour – DO NOT DELAY

1	Initial notification Unique Reference Number (e.g. KG/08/0001)		
2	Date / time of notification		
3	Name and title / role of caller		
4	Caller contact number		
5	First and other names of child		
6	Family name of child		
7	Date of birth of child		
8	Sex of child		
9	Ethnicity of the child		
10	Home address of child		
11	Postcode of child's home address		
12	Carer of child at time of death		
13	Name/s of persons with parental responsibility i.e. mother, father or other (state relationship)		
14	Other children in household or affected by the death (including children potentially at risk of harm)	Names (PRINT)	Ages / date of birth (if known)
15	Date and time of death		
16	Place / locality of death		
17	Contact number of place of death		
18	Summary description of the circumstances of the death		
19	Is this an unexpected death? i.e. not expected in the previous 24 hours	YES / NO	
20	GPs name		
21	Signature / name of the caller Sign and PRINT		
22	Date		

Please fax the form to the relevant LSCB Single Point of Contact. The fax should be marked STRICTLY CONFIDENTIAL

See **www.londonscb.gov.uk** for contact details of the Single Point of Contact for each London LSCB.

Initial notification Unique Reference Number

The table contains identification codes used by the Territorial Police in the MPS for the 32 London Boroughs (You will see the corresponding letters on the shoulders of officers patrolling the local areas). In addition there is a suggested code for City of London that is not a Metropolitan Police area but for Safeguarding Children processes is aligned with Hackney LSCB. (This additional designation code may be required or not)

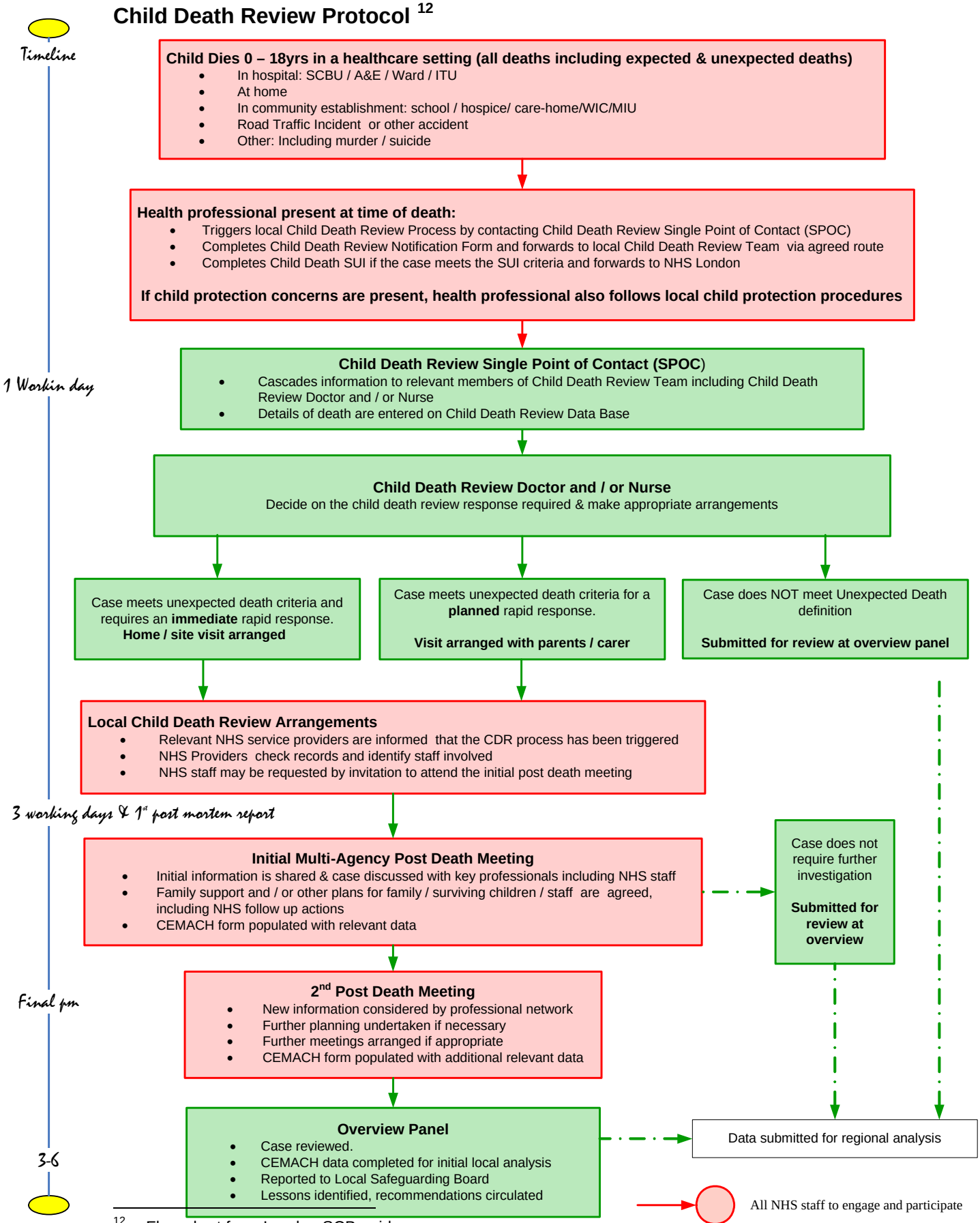
The suggested format for each Single Point of Contact to use from 1st April 2008 will be to use the code followed by the year and then a sequential number using four spaces. Thus the first report of a death of a child in Barking & Dagenham would be recorded as **KG/08/0001.**

Alphabetical Boroughs List of Codes

Borough	Code	Borough	Code
Barking & Dagenham	KG	Hounslow	TX
Barnet	SX	Islington	NI
Bexley	RY	Kensington & Chelsea	BS
Brent	QK	Kingston upon Thames	VK
Bromley	PY	Lambeth	LX
Camden	EK	Lewisham	PL
City Of London	CI	Merton	VW
Croydon	ZD	Newham	KF
Ealing	XB	Redbridge	JI
Enfield	YE	Richmond upon Thames	TW
Greenwich	RG	Southwark	MD
Hackney	GD	Sutton	ZT
Hammersmith & Fulham	FH	Tower Hamlets	HT
Haringey	YR	Waltham Forest	JC
Harrow	QA	Wandsworth	WW
Havering	KD	City of Westminster	CW
Hillingdon	XH		

For Bracknell Forest ??

Child Death Review Protocol [12]



[12] Flow chart from London SCB guidance