Primary Care Directorate
Death Reporting Policy

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Version Control Summary

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1.0 Introduction

The death of patients is increasingly taking place in their own homes, as support from community staff is effective in allowing patients to be cared for by their families. The practice will therefore generally be notified of the death of a patient via a third party – community staff, relatives, nursing/residential home staff, out-of-hours providers or others, which may include the police or coroner's office. Effective communication is essential in these circumstances in order to inform appropriate staff and others involved in the care of the patient to ensure that they are aware of the event.

Effective procedures are essential to check the details of the patient that has died and to avoid any errors with next of kin. So, checking patient, name, age, NHS number and address will minimise any possible mistakes. Currently in the UK there is no precise legal definition of "death", although guidelines do exist relating to the conduct of an examination where this is to take place, and deliver a confirmatory diagnosis. It is however beyond the scope of this procedure to specify these clinical requirements.

2.0 Certification

The death will be managed according to the circumstances, location, whether it was expected or unexpected, or whether suspicious circumstances exist. It is essential that both attending doctors and staff dealing with bereaved families are supportive both in a sympathetic way and are able to offer factual advice.

A Death Certificate may be issued by a doctor who has provided care during the last illness and who has seen the patient within the last 14 days of death. The Death Certificate is required to enable a funeral to proceed. It is issued to the next of kin to produce to the Registrar when registering the death. If the Registrar decides that the death does not need to be reported to the Coroner then they will issue a Burial Certificate, a Certificate of Registration of Death (for Social Security), and copies of the certificates, which may be used for the purposes of other organisations such as banks, building societies etc.

If the deceased is to be cremated, the doctor who signed the Death Certificate will complete part B of the Cremation form, and a second doctor (not connected to the first doctor's partnership) with more than 5 years post-qualification experience may examine the body, satisfy themselves of the circumstances of the death, and sign Part C. This certificate will be passed to the undertaker for presentation to the crematorium officers, where it will be checked.

3.0 Reporting Death to the Coroner

- Violent death
- Deaths where the doctor has not attended within the last 14 days
- Cause of death is unknown or uncertain
- Unknown identity of the deceased
- Death due to drugs or alcohol
- Death within 24 hours of a hospital admission
- Doubtful stillbirth
- Death related to surgery or anaesthetic
- Death in prison

In some cases, a death certificate may be issued but an alert may be generated on the reverse of the certificate to the effect that further action may be required. Examples are:

- Death from industrial disease
- Death of a patient receiving a war pension or industrial pension
- Suicide, poisoning or drugs
- Illegal abortion
- Death from neglect or exposure

The legal responsibility to report to the Coroner rests with the Registrar however it is also good practise for a GP to report directly if appropriate.

4.0 Unexpected Death

If death occurs at the patient's home, in a nursing home, or a residential home a visit by the GP to confirm death may take place – but this is not a statutory requirement. The GP should then report the death to the Coroner. In any other circumstances, a request to attend may be from the police or the ambulance service. These calls should be declined and advise the caller to obtain the services of a police surgeon.

Unexpected deaths may be of 2 main types – those where there is evidence of violence or unnatural causes and those where there is not. GPs should not normally attempt to distinguish between these 2 types and leave the investigation to a forensic clinician or police surgeon.

5.0 Expected Deaths

Where the GP who attend the patient during his/her last illness is available they should normally attend to certify death. The GP should notify the Registrar of the cause of death (to the best of his/her belief) via the certification procedure. It is also important to advise of any advance disclosure form of wishes.

6.0 Informing the Team

It is important that all members of staff are informed immediately of any patient death to minimise any possible distress to members of the family of the deceased through any inappropriate communication. Care should be taken to ensure that any notification is genuine and official. When a clinician or any other staff member receives notification of a death they will immediately inform all clinicians and the administration team via task, It is important that this is done as soon as possible. The patient's computer records will be updated indicating that the patient has died. A bereavement alert will be added to the records of any patients listed in the deceased patient's next of kin details.

A check should be performed to see if the patient is on the District Nursing / CPN / Community Matron / Health Visitor caseload and ensure that appropriate team leader (or nominated deputy) is notified of the patient's death. It is extremely distressing for relatives of deceased patients to receive any form of contact from practice or attached staff who are unaware of their bereavement.

Immediately upon receipt of notification of death, all practice team members will review their workload/caseload to ensure that the deceased patient is excluded from:

- Re-issue of repeat prescriptions requested prior to death
- Disease monitoring/prevention invitations (and any other practice correspondence)
- Scheduled home visits
- Pre-booked appointments for doctors and nurses
- Notify pharmacy if patient had delivered medication

We must ensure that post-out/repeat prescriptions are checked and any items addressed to this patient are removed. If the patient is a child, the Health Visiting team must be notified as soon as possible. If the patient is under the care of any hospital or trust (and if the death occurred outside of the hospital) the appropriate consultants/departments must be informed.
[Arrangements for immunisation call and recall vary in different area – child health teams should be notified to ensure that immunisation reminders are not sent.]

7.0 Electronic Systems

Immediately on notification of death the Read Code must be added to the patient record. In addition, a note is to be made in the clinical system to confirm the specific notifications of death made to individual community / secondary care / team members.

Additionally, a Datix incident must be raised recording the type of death (expected, unexpected). The Datix record should include as much information as is available to ensure that the Incident Reporting team and Grading Panel are able to effectively review the incident. The patient details must be added into the contact section of the incident form. All deaths must be reported on Datix as soon as the Practice becomes aware that a patient has died.