Policy / Procedure Details	Title:	**Managing and Reporting a Death in Service**		
	Type:	**Services**		
	Code:	**2A.15**		
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Current Version Details	Written By:	**David Tuomey, Principal Social Worker** **Regina Chambers, Social Work Team Leader**		
	Reviewed By:	**Leadership Team**		
	Approved By:	**Executive Director**		
	Date Released:	**10/ 06/ 2016**		
	Monitoring Process:	**Procedural Review Process**		
	Date Due for Review:	**10/ 06/ 2019**		

1. Introduction

The death of a Service User, whether expected or unexpected, can be devastating for family, staff and other people using services. The purpose of this policy is to ensure that Western Care Association responds in a sensitive, timely and appropriate manner.

2. Scope

The policy refers to any of these occurrences:

- Death occurring suddenly in a residence, respite or a day centre
- Death occurring after illness
- Death occurring on holidays, day trip or outing
- Death occurring due to accident or incident
- Death occurring after a person in residential services has been transferred to hospital.

3. Responsibility

It is the responsibility of all employees to be familiar with and to adhere to this policy.

It is the responsibility of all relevant Senior Managers to ensure employees are familiar with the policy, know how to access it and to monitor compliance.

It is the responsibility of the relevant Senior Managers to report the death of a Service User appropriately as outlined in the policy

The Executive Director will convene an End of Life Review Meeting with a group comprising the Principal Social Worker and others deemed relevant to review each death in Western Care services.

4. Process of Managing the Death of a Service User

Care of Deceased and their Family:

- The person or persons who discovers the body or are present when the death occurs must inform the member of staff with lead responsibility working in the service at the time of death

- The lead employee or the person(s) discovering the body or who is present when the death occurs should call emergency services or a doctor immediately (preferably the Service Users GP) if one is not present at the death

- The lead person, if they are not the Frontline Manager, should ensure that the Frontline Manager is contacted at the earliest opportunity. In the event of being unable to make immediate contact with the Frontline Manager, to avoid delay, make contact with the relevant Senior Manager.

- The Frontline Manager or relevant Senior Manager will ensure that family or next of kin are informed immediately and they should be invited to see their relative if they wish. Explore with the family any appropriate rituals that can be facilitated in line with their beliefs

- Best practice would indicate that families during this difficult time are better supported by one named staff as a *family liaison person* who will coordinate support and be a conduit for information between family and service and vice versa. Typically, this should be a staff member who knows the family well and has a good relationship with them

- In the event of the body being removed from Western Care Services by emergency services before the family has the opportunity to view their relative, the named family liaison person should be present, if possible, in the hospital for the arrival of the family or next of kin to be an immediate support

- All people present in the service at the time, both those supported and staff, need to be informed in a sensitive manner that takes into account their closeness to the deceased person

- All people involved with the service, both those supported and staff, who are not present at the time will need to be informed subsequently in a sensitive manner that takes into account their closeness to the deceased person

- Offer support to the family and where appropriate enquire as to their wishes regarding the needs for the person. We may continue to support family members in some way in the weeks/months following the death

- If the person has left particular instructions regarding their preferences regarding funeral arrangements and/or disposal of assets, property, possessions, etc., these should be respected

- The person's family has primacy in the planning of funeral arrangements etc., unless specifically requested by the person that his/her family not be given primary control over planning the funeral, etc. These wishes should be recorded in the individual's end of life plan if this exists for the person

- In the event of the deceased person not having a family or next of kin, Western Care Association will undertake all necessary arrangements and follow up, e.g. registration of death.

Impact of Death of Service User on Others:

- The death of a service user, whether sudden or anticipated, can have a devastating effect on other service users and staff

- Many people with an intellectual disability may have lived together and/or attended the same day centre for a considerable time

- Similarly, the impact of loss can be huge on staff who are also likely to have known the person for a considerable time

- Support is crucial for all those involved at this sensitive time

- Staff may need to be prepared to undertake many of the practical arrangements such as the registration of the death, funeral arrangements, etc, perhaps in consultation with the family

- Staff will also need to inform all relevant people, including families of other service users

- It is important to identify those service users who are likely to grieve for the deceased and to ensure that they get the support needed to help them through the grieving process

- Individual staff members may need to access bereavement counselling support to help them cope with their feelings and reactions

- Family members are likely to turn to staff for support as the people who knew the deceased well

- All people involved in a person's life will need variable support when the person dies and afterwards. (See Loss and Bereavement Procedure)

Requirements:

- The Death of Adult/Child in Service Report form (See Appendix 1) must be completed by the Senior/Regional Services Manage / Head of Department and forwarded to the Executive Director within one working day; exceptions to this will be agreed with the Regional Services Manager and Executive Director

- If the deceased Adult/Child is using services in a Designated Centre that falls under the HIQA Regulations, then the required notification form should also be completed. The Service Manager must be involved in this process

- If in the event of the death being sudden or unexpected, the Executive Director will convene a meeting within one working day

- The person in charge will co-ordinate the completion of service reports by all staff involved with the care of the Service User leading up to and at the time of death. Where necessary, a report by the Senior/Regional Services Manager / Head of Department will be forwarded to the Executive Director

- The Executive Director may choose to commission an internal or external report into the death of the individual

- A review of the circumstances of the death will be undertaken by the Executive Director, Senior/Regional Services Manager / Head of Department and key additional staff. Following this review, the Executive Director will convene an end of life review group involving key personnel and determine whether an independent review is required. In addition, key learning and recommendations should be agreed and a process for implementing such recommendations put in place at this meeting. All necessary documentation should be finalised at this stage. The review will take into account any relevant information or recommendations by the Coroner.*

* *Note:* A Coroner in Ireland is an independent official with legal responsibility for the investigation of sudden and unexplained deaths. The role of the Coroner is to enquire into the circumstances of sudden, unexplained, violent and unnatural deaths.

External Notifications:

- The Executive Director will inform the HSE Disability Manager and/or HSE Case Manager/Liaison Officer

- The Principal Social Worker will inform the Ward of Court Office, if the Service User is a Ward of Court

- The Executive Director will inform the Gardai of any suspicions or concerns regarding the death of a Service User and ensure that instructions from Garda are followed through

- Person in charge will inform HIQA in line with relevant regulations.

5. Service User's Personal Belongings

The Person in Charge, in conjunction with relevant Senior Manager, will ensure that the following is carried out.

If the person has left instructions stating their preferences for the disposal of their property or goods, etc., these wishes shall be followed. In addition, the following shall apply where consistent with such wishes:

- An inventory should be prepared of all personally owned items in the Service User's apartment/bedroom. This inventory should be signed by the Regional Services Manager and witnessed by a staff member and, if possible, a member of the Service User's family

- In discussions with family/relatives, the removal of these items should be noted on the inventory – any donations must be noted clearly and a receipt given for each donation

- Monies/accounts held on behalf of the Service User, after deduction of any funeral or other expense necessarily incurred, will be identified and lodged back into the Service User's bank account. Details of bank accounts and where they are held, will be passed on to the Service Users next of kin and Western Care Association will endeavor to assist the next of kin as much as possible in dealing with third parties. (See Regulations for Service Users Monies procedure)

6. Media Involvement

In the exceptional circumstances where the media may have interest in the death which has occurred, the Executive Director will be responsible for collecting and disseminating information to them. All requests for information should be directed to the Executive Director's office. It is important that all areas work closely with his/her office to maintain the accuracy of the information disseminated.

It is important that no person involved in the response of the services speculate as to the cause of death or make statements assigning responsibility for the cause of death to any individual or group. Requests for such information by the media must be directed to Executive Director.

Policy and Procedure Feedback Form

A Policy and Procedure Feedback Form is available on the Western Care Association Intranet (under Procedures) which will provide an opportunity to comment on any policy/procedure.
Your comments will be forwarded to the person who has the lead for the on-going development of the policy/procedure.
All comments will be collated by the person responsible and will inform the three-yearly review cycle for updating procedures.

Death of Adult/Child in Service Report

Name of Deceased Individual:_____ Pin No.:_____

Address:_____

D.O.B.: _____

Name of Staff on Duty when the Death occurred:_____

Name of Service:_____

Date of Death:_____ Time Death was discovered (if in centre):_____

Time of Death as pronounced by GP or Hospital Doctor:_____

Next of Kin:_____

Description of Circumstances and Any Medical Condition of the Person prior to or contributing to their Death:

_____
_____
_____
_____

Any emergency services contacted for life saving intervention?

_____
_____
_____
_____

Were Gardai contacted?_____

Did Gardai attend?_____

Name of attending Garda:_____

Who certified Death?_____

Who contacted the Next of Kin?_____

Date of Contact:_____

Was a Post Mortem requested?_____

Is there a Coroner's Inquest pending?_____

Cause of Death (as recorded on Death Certificate):_____

If Cause of Death is not available, please give Reasons Why and state When this Information is expected to be available:

_____
_____
_____
_____

Describe any Observations or Medical Interventions in relation to the Person's Health over previous month/s:

_____
_____
_____
_____

Results of Postmortem (if any):

_____
_____
_____
_____

Any additional Comments/Feedback that would be useful when submitting this report including any other Important Matters you consider relevant to the Death:

_____
_____
_____
_____

Are there any Outstanding Issues relating to the Deceased's Estate which need to be addressed?

_____
_____
_____
_____

Any Debriefing undertaken or required?

_____
_____
_____
_____

Signed:_____ **Date:**_____

To be forwarded to the Executive Director within <u>One</u> working day.

CC: **Main File**

Report on Review of Death

To: End of Life Review Group, Western Care Association Head Office

Name of Deceased: _____

Western Care Association Service: _____

Date of Birth: _____

Date of Death: _____

Location of Death: _____

Date of Death of Child/Adult in Service Report completed: _____

1. Background (about the person)

2. Medical History prior to Death

3. Brief overview of Facts Surrounding Death (include cause of death, if known)

4. Care provided prior to death (review medication administration, daily notes and any other relevant documentation)

5. Other relevant observations

6. Recommendations (where relevant)

7. Plan for implementation of recommendations (where relevant)

Completed by: _____

Signature: _____

Job Title: _____

Date: _____

Death in Service: Timeline for Tasks

Action	Day 1 0-24hrs	Day 2 24-48hrs	Day 3 48-72hrs	Day 4 72-96hrs	Day 5-14	Day 15-29	Day 30-44	Day 45-59	Day 60-74+
Certify Death	✓								
Notify Coroner	✓								
Notify Family	✓								
Notify Next of Kin	✓								
Notify Staff/Others	✓	✓							
Secure Personal effects	✓	✓	✓	✓					
Hand over personal effects					✓				
Prepare for funeral	✓	✓							
Attend funeral			✓						
Prepare report						✓			
Follow up actions							✓	✓	✓
Post mortem report									✓