Death of a Customer Procedure

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Approved by: Care and Support Executive Team

Lead Director: Director of Quality and Improvement

In consultation with: Operational teams, Quality and Improvement, Health and Safety

Link to Procedure: Serious Untoward Incidents Procedure

Equality Impact Assessment Date: 14 August 2023

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1. Procedural Context

Riverside is committed to enhancing the safety of our customers, their families and carers, our staff and the public by ensuring that we have robust systems to report and learn from deaths. This procedure sets out the systems, processes and requirements for reporting and managing deaths, a system of classification and guidance on when to investigate the death of a customer. It also identifies support available to colleagues who have been affected by a death.

This procedure is based on the following principles:

- A culture of learning and openness is required to improve safety.
- The needs of those affected should be the primary concern of those involved in the response to a death. Customers, their families and carers and staff must be involved and supported throughout the process in an open and honest way.
- All deaths should be reported and managed efficiently and effectively.
- When Serious Incident Investigations are required these are conducted for the purposes of learning to prevent or reduce the likelihood of recurrence. They are not conducted to hold any individual or organisation to account.
- Learning from deaths should be shared with all levels of the organisation to improve service delivery.
- Riverside will cooperate with other providers, safeguarding teams, commissioners and regulators to support the investigation of deaths and subsequent learning.

All Procedures referred to for Care and Support can be found on the RIC

2. Application

This procedure applies to all customer deaths within Riverside's Supported Housing, Retirement Living and Care services.

All colleagues should read and understand this procedure along with the Serious Untoward Incidents Procedure which provide guidance and support on how to deal with the death of a customer and serious untoward incidents.

3. Categories of death

Every death should be classified into a category (see table below for details) when completing the Death of a Customer Form. This supports the process of learning from deaths and provides a reporting structure for the Annual Mortality Review.

Category	Investigation Level
Natural Causes The customer's death is expected and is due to natural causes, e.g. death through old age	Report on SAW-IT and complete Death of a Customer form.
Medical	Report on SAW-IT and complete Death of a Customer form.

The customer's death is expected and is due to a medical issue/illness, e.g. cancer.	
COVID-19 The customer's death is as a result of Covid-19 or within 28 days of testing positive for this.	Report on SAW-IT, on the Coronavirus form, and complete Death of a Customer form.
Substance overdose/Suspected Substance Overdose The customer's death is due to a confirmed or suspected substance overdose.	Report on SAW-IT and complete Death of a Customer form. A Serious Incident investigation is required. The Serious Untoward Incident Procedure should be followed.
Suicide/Suspected Suicide The customer's death is due to a confirmed or suspected suicide.	Report on SAW-IT and complete Death of a Customer form. A Serious Incident investigation is required. The Serious Untoward Incident Procedure should be followed.
Not known at this time - Suspected Medical The reason for the customer's death is unknown but is suspected to be due to a medical issue/illness, e.g. cancer.	Report on SAW-IT and complete Death of a Customer form. Consideration should be given to whether a Serious Incident investigation is required depending on the circumstances *(refer to Appendix 1 of the Serious Untoward Incident Procedure for guidance)*
Not known at this time - Not Suspicious The reason for the customer's death is unknown. The circumstances around the death are not considered to be suspicious.	Report on SAW-IT and complete Death of a Customer form.
Not known at this time – Suspicious The reason for the customer's death is unknown. The circumstances around the death are considered to be suspicious. Real life past examples of this include: • *A customer died as a result of a stabbing, but at the time it wasn't evident if the stab wounds were self-inflicted or by another person.* • *A customer fell as a result of being pushed down a set of stairs, however without the death certificate we were unable to know the true reason (although it would appear it was as a result of the fall).*	Report on SAW-IT and complete Death of a Customer form. Consideration should be given to whether a Serious Incident investigation is required depending on the circumstances *(refer to Appendix 1 of the Serious Untoward Incident Procedure for guidance)*

Where any additional information arises from the death of a customer at a later date, for example, the cause of death from a coroner's inquiry, this should be sent to the DiS inbox so it can be updated on the Death of a Customer form and SAW-IT system.

4. Duties and responsibilities

Where a death of a customer is discovered the following process must be followed. **Please note all stages / actions below should be completed within 24 hours.**

1. Upon discovering a death the relevant ROM and Head of Operations should be informed immediately so they are aware of the incident
2. Death to be reported on SAW-IT by service staff
   - Death of a customer form to be completed by service staff and sent to Line Manager
3. Line Manager to quality check form and send to SP Provider Coordinator for services who are using SPP. ***If SPP is not in use go directly to step 5***
4. SP Provider Coordinator to complete SPP review and send back to relevant operational colleagues to input learning outcomes
5. Service/Area Manager to complete learning outcomes section and send to ROM for sign off
6. Once approved ROM to send to their appropriate Head of Operations
7. Once approved Head of Operations to send to Death in Service (DiS) inbox: C&SDiSReports@riverside.org.uk

The Death of a customer form can be found on the RIC

Other responsibilities are listed in the table below:

Role	Responsibility
Director of Quality and Improvement	• Ensuring that robust procedures, systems and processes are in place for the reporting, investigation, management and learning from deaths.
Director of Operations	• Ensuring the C&S management structure develops effective relationships locally with commissioners and regulators to provide confidence in the organisation's ability to report, investigate, manage and learn from deaths.

All managers	• Ensuring compliance with this procedure and other systems and processes. • Taking immediate action following a death to support people who are affected, preserving any evidence for any potential future investigation and implementing any required immediate safety measures to prevent further harm; e.g. ensuring a property is made safe.
All colleagues	• Taking responsibility to ensure your own safety, and the safety of others. • Cooperating fully with management and any other person conducting an investigation into a death. • Completing a death of a customer form where applicable and reporting on SAW-IT as soon as possible (within one working day) • Dealing with customers involved in any death to an individual, to ensure appropriate support is available where needed.

5. Reporting

As per the above flowchart all deaths are to be reported on SAW-IT and a Death of a customer form completed. This should be done as soon as possible and within 24 hours of the incident occurring or it being known a death has occurred.

The requirement to report includes deaths in a customer's own home, hospitals, Riverside services/schemes, deaths from natural causes etc. It also includes where there may be a death of any visitor who is on site at the time.

This enables Riverside to monitor and report on any trends ensuring investigations and learning can take place.

The death of a member of staff or any other personnel connected with Riverside should also be recorded on SAW-IT and the Serious Untoward Incident Procedure followed.

Information and guidance about the SAW-IT system can be found on the Health, Safety and Environment page on the RIC.

Deaths that are unexplained and/or may attract immediate media attention should be escalated through the line management structure, and the marketing and communications team informed where required. If the incident occurs during out of hours, the 'On-Call Procedure' should be followed to ensure it can be escalated appropriately.

Commissioning

Where required, serious incidents such as deaths, will be reported to appropriate commissioners, usually done by an Area Manager, within 48 working hours of the

incident occurring or Riverside becoming aware of the incident occurring. *Note - timescales for reporting incidents may vary for certain services depending on any contractual requirements from your Local Authority so these should be considered.*

CQC Registered Services

Services which are registered with the Care Quality Commission (CQC) are required to provide notification of the death of any person using the service, who are in receipt of a care package. The 'Death of a Person Using the Service' form, which can be submitted via an online portal or via form is located on the CQC website and must be completed at the earliest opportunity (usually by the next working day) by the Registered Care Manager, Service Manager or designated person. A copy of the downloaded notification or CQC form, must be sent to the Riverside Care Services team on care.services@riverside.org.uk

6. Procedures

Immediate Actions

On discovery of a body whether in a scheme or at a customer's home the following immediate actions should be taken:

- Call emergency services (999) IMMEDIATELY and take instruction from them.
- Do not attempt Cardio Pulmonary Resuscitation (CPR) before contacting emergency services.
- Make a note of the time.
- Ensure the environment is safe.

There may be occasions when a colleague discovers a customer who has obviously been dead for a considerable period of time and attempting CPR would not be appropriate. E.g.

- The body is cold or at room temperature.
- Rigor Mortis[1] has set in.
- There are no signs of life.

It is important that all information is communicated to the emergency services on the situation. We are not qualified to diagnose rigor mortis, or make decisions on attempting CPR, so all colleagues should follow the advice and instruction given to them by the 999 operator.

Police Involvement

If the police are involved:	The police are responsible for:
• Provide the police with Next of Kin details and cooperate fully with police requests.	• Contacting the Next of Kin. • Arranging for the attendance of the police surgeon who will certify the death.

[1] Stiffening of the limbs – occurs from 2 -6 hours after death

• DO NOT contact the Next of Kin unless requested to by the police – this is the responsibility of the police. • DO NOT touch the customer's room or possessions without police permission. • Contact the Service Manager or On-Call Manager so it can be escalated appropriately. • The manager will then contact the Regional Operations Manager or Senior On-Call Manager. • Make detailed notes on the customer's records. In the event the electronic system is not available, written notes should be taken and then entered retrospectively.	• Arranging for the removal of the body; where the police have no further interest in the death this may be undertaken by the Next of Kin. • Informing the Coroner's Office of the death. • Giving permission for family members to access the possessions of the deceased. • Potentially conducting interviews with individuals who found the body.

Please note where the police first attend the scene, they may ask any colleagues present for a statement on what has taken place. In these instances colleagues are encouraged to defer making a statement at this time and inform the police that they must first take legal advice as per Riverside's internal procedure. Colleagues should then liaise with their line manager to prepare a statement on what has taken place and engage with our in-house legal team to sign this off before sending back to the police where necessary. For guidance on how to access support and advice from our legal team please refer to our Legal User Guide which can be found on the RIC.

Follow up actions

- In cases where there is no police involvement and death is confirmed by ambulance staff they will normally contact the customer's GP who should attend urgently to issue a death certificate. They may also contact the Coroner's Office where necessary.
- Riverside staff should inform any other agencies involved in the care of the customer and update the system (SP Provider/Open Housing) to confirm this has been done.
- If there is a surviving partner it is important they are kept fully informed regarding their continuing tenancy rights. Please refer to Succession Rights Procedure (for Tenancy Agreements) where required.

Collection of belongings and Ending a Tenancy

For guidance on how to arrange collection or disposal of items / customer belongings and how to end tenancies please refer to *'Appendix 1 - Collection of belongings and Ending a Tenancy.'*

Funeral Arrangements

Funeral arrangements should be made by the customer's Next of Kin or other family. In the absence of this the service Manager should contact the appropriate Social Services Department who have a duty to make arrangements for a burial or cremation.

Colleagues can become very close to customers over time and Riverside recognises the importance of allowing colleagues to grieve and express their sorrow. Where the family request/permit it, or where there is no Next of Kin, colleagues who wish to do so, should be supported to attend the funeral service, as a representative of Riverside. Service Managers should make every effort to facilitate this.

Faith at the end of life

It is vitally important to respect a customer's faith and beliefs at the end of their life. Different faiths have different customs and practices that should be respected. Public Health England provides a clear and comprehensive resource which can be found in *Section 11. References and Resources – 'Faith at the end of life'.*

Cause of Death

The cause of death should be recorded, where known, to support learning from deaths and to inform the Annual Mortality Review. Where any additional information arises from the death of a customer at a later date, for example, the cause of death from a coroner's inquiry, this should be sent to the DiS inbox so it can be updated on the Death of a Customer form and SAW-IT system.

7. Coroner's Inquests

When a death is unexpected, violent or unnatural, the Coroner will decide whether to hold a post-mortem and, if necessary, an inquest. The Coroner's court is a court of law, and accordingly the Coroner may summon witnesses to attend and give evidence.

If we are notified that a Coroner's Inquest will take place the relevant Regional Operations Manager and Head of Operations should be informed immediately. The Regional Operations Manager should set up a project group made up of relevant colleagues who will manage and oversee the process and ensure legal advice is sought where required. The Regional Operations Manager will act as the project lead and be responsible for ensuring actions are completed and within agreed timescales.

Colleagues should refer to '***Appendix 2 – A short guide to Coroners Inquests'*** for further information about our approach and additional support available for any individuals involved.

Any colleagues due to attend an inquest should also refer to ***'Appendix 3 – Attending an Inquest (Frequently Asked Questions)'*** which is an FAQ document taken from an information booklet developed by Weightmans Solicitors and provides additional practical advice as to what colleagues can expect on the day of the inquest and how to prepare.

8. Learning from deaths

Wherever a death is investigated the overall aim is to identify if there are any areas of learning for the organisation. An action plan will be developed in response to the report recommendations that ensures the learning is turned into tangible improvements in service delivery.

Managers should ensure learning is shared within their team. This must include providing feedback to the person who dealt with the incident, as this encourages further incident reporting and learning. The timeframe for being able to feedback learning may vary, e.g. involvement from a coroners court, but where possible this should be shared and fed back to relevant colleagues without any undue delay.

The Director of Operations and Senior Management team are responsible for ensuring that learning from deaths is implemented, making improvements to service delivery, and sharing learning with other services / areas as appropriate.

The Quality and Improvement team will develop an Annual Mortality Review to ensure we are able to monitor and report on any trends, and ensure learning and improvements can take place where required.

9. Being open (Duty of Candour)

Whilst the principles of Being Open and the Duty of Candour relate to NHS patient safety incidents and Care Quality Commission (CQC) registered services, Riverside expects the same principles to be applied to all incidents that occur within the organisation irrespective of whether they are regulated by the CQC including staff incidents.

Riverside has a moral and legal duty to be open with customers, their families and carers when a death has occurred. This duty is detailed in CQC Regulation 20: Duty of Candour and must be applied in all circumstances. Further information can be found in the link below:
Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)

Early, meaningful and sensitive engagement with affected customers, their families and carers should be established from the point at which an incident is identified and throughout the investigation process. This will normally be the Service Manager or for serious incident investigations, the Incident Investigator.

10. Support for colleagues

Riverside recognises that colleagues who are involved in an incident may be affected by the event both in their work and on a personal level. Riverside is committed to supporting colleagues and will provide timely and appropriate support. The AXA Helpline is available 24 hours a day, seven days a week by calling 0800 072 7072. More information can be found on the RIC via the People Services page under Health and Wellbeing.

Following a Serious Incident, including the death of a customer, colleagues should be met face-to-face (wherever possible) by a manager who will ensure any support needs are identified and addressed.

More information about support available can be found in ***'Appendix 4 – Support for colleagues'***.

We also recognise that customers who are involved in an incident or death of a customer may be adversely affected and should be offered appropriate support in dealing with this, e.g. clinical supervision. In these situations staff are encouraged to contact a member of the Procurement team by emailing procurement@riverside.org.uk to find out what support/services we can commission.

11. References and Resources

Care Quality Commission (2015) - Fundamental Standards on Quality and Safety
http://www.cqc.org.uk/content/regulations-service-providers-and-managers

Faith at the End of Life
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496231/Faith_at_end_of_life_-_a_resource.pdf

Guidance - Refer a deceased person's estate to the Treasury Solicitor
https://www.gov.uk/guidance/refer-a-deceased-persons-estate-to-the-treasury-solicitor

Appendix 1 – Collection of belongings and Ending a tenancy

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Appendix 2 – A short Guide to Coroner's Inquest

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Appendix 3 – Attending an inquest (Frequently Asked Questions)

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Appendix 4 – Support for colleagues

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Appendix 5 – Useful Contacts

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Version	Date	Changes Made	By Who	Authorised
7.1	21.07.20	**Section 6 – Procedures** New heading inserted **"Closing a customer's account"** providing additional information on the process to follow when ending a tenancy and closing a customer's account on SP Provider and/or Open Housing.	Mark McKean	Simon Allcock
7.2	01.02.22	Updated all links to relevant information on the RIC site	Mark McKean	Simon Allcock
7.3	15.03.22	**Section 6 – Procedures** Amendments made to "**Collection of belongings / Ending the tenancy" section** following consultation with legal team providing additional information on our responsibilities where a customer passes away 'intestate' and the process to be followed.	Mark McKean	Simon Allcock
7.4	12.10.22	**Section 3 – Categories of Death** All Categories of death changed to new categories. Also updated on the Death of a Customer Form.	Mark McKean	C&S Executive Team
7.5	09.01.23	**Section 6 – Procedures** Additional information provided for colleagues where police attend a scene of death and ask for a statement and the steps colleagues should take including seeking advice from our in-house legal team. **Appendix 3 – Attending an Inquest (Frequently Asked Questions)** Additional appendix added which is an FAQ document taken from an information booklet developed by Weightmans Solicitors and provides additional practical advice as to what colleagues can expect on the day of an inquest and how to prepare.	Mark McKean	Simon Allcock
8.0	14.08.23	Formal review of the procedure undertaken in consultation with Operational colleagues and Quality and Improvement team. **Section 4 – Duties and Responsibilities** Additional responsibility added for Director of Quality and Improvement.	Mark McKean	C&S Executive Team

		Section 5 – Reporting Additional paragraph stating the requirement to report and investigate, where appropriate, the death of any visitor who is on site in a Riverside service at the time of their death. Additional paragraph covering reporting requirements to Local Authorities where there is a death. **Section 6 Procedures** Additional paragraph stating that colleagues must always follow the advice and instruction given to them by the 999 operator, when they discover a body either in a scheme or at a customer's home. Moved information on Collection of Belongings and Ending a tenancy into a separate appendix (Appendix 1 - Collection of Belongings and Ending a tenancy) **Appendices** All other appendices moved into separate documents which have been embedded into the procedure to reduce the overall length.		