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Management of a Death

Policy Number	1.120
Policy Function	Continuum of Care
Issue Date	19 January 2023
Summary	This policy provides health staff with clear guidelines for the management, recording and documentation of deaths in custody covered by Justice Health and Forensic Mental Health Network (Justice Health NSW)
Responsible Officer	Executive Director Performance and Planning
Applicable Sites	☒ Administration Centres ☒ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.) ☒ Health Centres (Adult Correctional Centres or Police Cells) ☒ Health Centres (Youth Justice Centres) ☒ Long Bay Hospital ☒ The Forensic Hospital
Previous Issue(s)	Policy 1.120 (January 2018; July 2013; April 2008)
Change Summary	• MoH PD2021_029– Death – Verification of Death and Medical Certificate of Cause of Death, no longer applies to Justice Health NSW • MoH Life Extinct form no longer applies therefore there is a need to adapt form to become a Justice Health NSW form (completed)
TRIM Reference	POLJH/1120
Authorised by	Chair, Policy Steering Committee

1. Preface

All deaths in NSW correctional Centres, Youth Justice Centres, Long Bay and Forensic Hospitals are subject to internal review and an investigation by the Coroner. Justice Health and Forensic Mental Health Network (Justice Health NSW) has developed this protocol for the management, reporting and documentation of the death of a patient.

This policy applies to the death of a patient in the Forensic Hospital, Long Bay Hospital, Correctional and Youth Justice Centres and patients in the community under the care of Justice Health NSW.

2. Policy Content

2.1 Mandatory Requirements

All-unexpected deaths must be notified in the *Incident Management System* (ims+) as Harm Score 1 and Harm Score 4 for expected deaths.

All deaths must be immediately notified to Justice Health NSW senior management via the executive group paging service.

It is mandatory under the *Health Administration Act 1982* which informs NSW Health Incident Management Policy PD2020_047 for Harm Score 1 clinical incidents to have Preliminary Risk Assessment (PRA) completed within 72 hours. A PRA is undertaken by a Chief Executive appointed panel to assist the Health Service to understand the events and identify immediate risks for action. A clinician will be appointed by the PRA to speak to the family/NOK for the purposes of Clinician Disclosure in accordance with the NSW Health Open Disclosure Policy (PD2014_028). A review utilising one of the approved Serious Adverse Event Review (SAER) methodology is to be completed within 60 days of the incident being logged in ims+.

All deaths in NSW Correctional and Youth Justice Centres, Long Bay and Forensic Hospitals are reported to NSW Ministry of Health (MoH) as a *Reportable Incident Brief* (RIB).

Where the death is 'expected', such as when a patient has a known serious medical condition, a death review is undertaken by the Clinical and Corporate Governance Unit using the *Death Screening Tool*. In accordance with the recommendations from the Clinical Excellence Commission's *Final Report of the Mortality Review Working Group* (June 2010), the death review procedure is a staged process that focuses on both inpatient and non-inpatient deaths that involves screening using a simple template with triggers, through to secondary review for patients with triggers to an SAER where required.

All deaths in NSW correctional and Youth Justice Centres, Long Bay and Forensic Hospitals are investigated by the Coroner who will issue a death certificate following examination of the deceased. Death certificates cannot be issued by a Justice Health NSW medical officer or any other person. Attendance of the Coroner's representative or NSW Police at the scene will be arranged by Corrective Services NSW (CSNSW) or Youth Justice NSW (YJNSW), in the Forensic Hospital this will be arranged by the Forensic Hospitals Director of Nursing & Services (DNS) and after hours by the Forensic Hospital After Hours Nurse Manager (AHNM).

Clinical findings must be documented by the nursing staff and, if in attendance, Medical Officer (MO), and the fact that the patient is deceased must be recorded in the patient's health record. There is no requirement to call the MO into the centre if there is not one on duty. Death of the patient may be documented by a MO if one is available; otherwise Justice Health NSW policy allows for a registered nurse (RN) to assess the extinction of life and give notification to relevant authorities. Justice Health NSW JUS010.515 *Life Extinct Form* found on Justice Health NSW Intranet must be completed by the MO or RN. The original form must accompany the original health record and a copy must accompany each copied health record.

2.2 Implementation - Roles and Responsibilities

The Forensic Hospital:

The Deputy Director of Nursing Forensic Hospital (DDN-FH), Director of Nursing & Services Forensic Hospital, (DNS-FH) and After Hours Nurse Manager (AHNM) responsibility:

- The DDN-FH will notify the DNS-FH who will then advise the Executive Director Clinical Operations (EDCO) who will brief the Chief Executive of events.
- During business hours the DNS-FH will contact NSW Police who will attend the death and act on behalf of the Coroner. Outside business hours the Forensic Hospital AHNM will contact NSW Police.
- The DNS-FH must advise Justice Health NSW executive group of the death of a patient using the Executive Group Page system.
- Outside business hours the Forensic Hospital AHNM must be notified on *1 or (02) 9700 3112, who will notify the DNS-FH who will then advise the EDCO who will brief the Chief Executive of events.
- The Forensic Hospital AHNM must advise Justice Health NSW executive group of the death of a patient using the Executive Group Page system.

Medical Officer's responsibility:

- To respond and assist with any clinical resuscitation if on site.
- Verify 'life extinct' in the patient's health record, and complete JUS010.515 *Life Extinct Form*, if on site and requested.
- Record all clinical findings and that the patient has died in the patient's health record if on site.

Psychiatrist or Registrar on duty responsibility:

- The Psychiatrist or Registrar on duty is to inform the next of kin (NoK) or designated carer. This may satisfy the PRA requirement of an appointed Clinician Disclosure, or the PRA may allocate a clinician for further follow up with the NoK or designated carer in accordance with NSW Health Open Disclosure Policy (PD2014_028).

Social Worker and or Welfare Officer Responsibility:

- To assist the Psychiatrist or Registrar on duty to inform the Next of Kin or family members.
- Inform the NSW Trustee and Guardian if applicable.
- For those patients who are not Australian citizens to contact relevant Embassy to notify of death.

Nurse's responsibility:

- To respond and perform any clinical resuscitation as required.
- During business hours notify the Nursing Unit Manager (NUM) immediately. If the NUM is not available, call the DDN-FH phone on 9700 3158.
- The Forensic Hospital AHNM must be notified immediately on *1 or (02) 9700 3112 if the death occurs after hours.
- The death of a patient must be recorded as a clinical incident in ims+. The ims+ number must be recorded in the patient's health record as soon as possible following the death. When death occurs in external hospitals it is the responsibility of the unit attending the Daily Hospital Update Form to complete an incident in the ims+.
- Justice Health NSW staff in attendance must document the events surrounding the death in the patient's health record.
- Verify 'life extinct' through required clinical assessment. Document this assessment on the JUS010.515 *Life Extinct Form* and also document verification in the patient's health record.
- Clinical notation in the patient's health record in relation to the death must be completed prior to ceasing duty.

- The health record of the deceased must be sent to Health Information and Records Service (HIRS) for photocopying after the patient's death. This must occur on the day of death including weekends and public holidays (same day via express courier if necessary).

NSW Correctional and Youth Justice Centres including Long Bay Hospital:

Nurse Manager Operations, Access and Demand Management (NMOADM) responsibility:

- During business hours the Access and Demand Nurse Manager must notify Justice Health NSW Director of Nursing and Midwifery Services (NDNMS) who will then advise the EDCO who will brief the Chief Executive of events.
- The Nurse Manager, Access and Demand must advise Justice Health NSW executive group of the death of a patient using the Executive Group Page system.

After Hours Nurse Manager's (AHNM) (state-wide) responsibility:

- The AHNM must notify the EDCO who will contact the Chief Executive and brief them on events.
- The AHNM must advise Justice Health NSW executive group of the death of a patient using the Executive Group Page system.

Medical Officer's responsibility:

- To respond and assist with any clinical resuscitation if on site.
- Verify 'life extinct' in the patient's health record, and complete JUS010.515 *Life Extinct Form*, if on site and requested.
- Record all clinical findings and that the patient has died in the patient's health record if on site.

Nurse's responsibility:

- To respond and perform any clinical resuscitation as required.
- During business hours notify the Access and Demand Nurse Manager immediately. If the Access and Demand Nurse Manager is not available, call the AHNM phone on 1300076267.
- The AHNM must be notified immediately on 1300076267 if the death occurs after hours.
- The death of a patient must be recorded as a clinical incident in ims+. The incident number is to be recorded in the patient's health record as soon as possible following the death. When death occurs in external hospitals it is the responsibility of the Health Centre attending the Daily Hospital Update Form to notify on ims+.

- Justice Health NSW staff in attendance must document the events surrounding the death in the patient's health record.
- Verify 'life extinct' through required clinical assessment. Document this assessment on the JUS010.515 *Life Extinct Form* and also document verification in the patient's health record.
- Clinical notation in the patient's health record in relation to the death must be completed prior to ceasing duty.
- The health record of the deceased must be sent to Health Information and Records Service (HIRS) for photocopying after the patient's death. This must occur on the day of death including weekends and public holidays (same day via express courier if necessary).
- Justice Health NSW staff in attendance must contact Justice Health NSW Legal Advisor for assistance in completing a draft statement for the Coroner. This must occur within 7 days.

Clinical and Corporate Governance Unit

Program Manager Patient Safety responsibility:

- To coordinate the completion of the Reportable Incident Brief (RIB).
- For unexpected deaths, the Program Manager Patient Safety coordinates the PRA team and confirms the selected SAER review method.
- Notify Director Aboriginal Strategy and Culture of any death of an Aboriginal or Torres Strait Islander person.

Health Information and Records Service (HIRS)

- Make an authorised electronic copy of the complete electronic and paper record.
- Provide copies of the health record to Patient Safety Manager and Legal advisor as soon as practical for SAER review to commence without delay.

3. Procedure Content

3.1 Assessment and Certification of Life Extinct and the Certification of Death

This policy makes a distinction between the assessment and certification of life extinct and the certification of death.

3.1.1 Assessment and Certification of Life Extinct

The assessment of the extinction of life is a clinical assessment process undertaken to establish that life is extinct. By evaluating cardiac output, neurological signs and respiratory status, a

registered medical practitioner or RN can establish that life is extinct. This assessment must be documented on Justice Health NSW JUS010.515 *Life Extinct Form*. This applies even if CSNSW officers/YJNSW staff have commenced CPR before nursing staff arrive at the incident.

For patients in cardio-pulmonary arrest, resuscitation attempts must be undertaken whenever there is a chance of survival, however remote, unless an Advanced Care Directive is in place – see NSW MoH Guidelines GL2021_004 *End of Life Decision Making*. Nevertheless, it is possible to identify patients in whom there is absolutely no chance of survival, and where resuscitation should not be attempted as it would be both futile and distressing for healthcare personnel. Such conditions include massive destructive injuries of the head and/or torso, decomposition, incineration, hypostasis and rigor mortis. This applies even if CSNSW officers/YJNSW staff have commenced CPR before nursing staff arrive at the incident.

3.1.2 Certification of Death

All deaths in custody (DIC) are investigated by the Coroner. A Death Certificate cannot be issued by a Justice Health NSW medical officer or any other person. The Coroner will issue the Death Certificate following his/her examination of the deceased. The attendance of the Coroner's representative or NSW Police at the scene will be arranged by CSNSW/ YJNSW in accordance with their own policies. Within the Forensic Hospital, during business hours the attendance of the Coroner will be organised by the DNS or delegate and after hours by the Forensic Hospital AHNM.

3.2 Guidelines for Nursing Staff and Medical Officers

As all DICs are Coroner's cases, nothing must be done to the body or the scene after death. Justice Health NSW staff must be aware that NSW Police investigations require that equipment remain in situ and must not be removed i.e. IV cannula, needles, drains, airways and attached intravenous fluids, lines (and enteral feeding equipment) must accompany the body to the morgue.

All sharps or pieces of equipment left in situ must be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised. The immediate area must be checked and any sharps or equipment not required to remain in situ must be removed for disposal or bagged for processing.

If Police Officers require re-usable equipment from the emergency backpack to remain in situ, the Nursing Unit Manager/Nurse in Charge (NUM/NIC) is responsible for ordering replacements. Once returned, the re-usable equipment from the emergency backpack must be cleaned in accordance with Justice Health NSW Infection Control Guidelines.

In the event that any material and/or vomitus is removed or suctioned from the airway or stomach, this must be retained and placed in screw-capped container(s) (i.e. V-VAC bottle and cap)

appropriately labelled and forwarded with the body. Standard infection control precautions must always be observed.

The scene of a death becomes a crime scene and any material/items (e.g. bedding, linen) that were initially present at the scene must not be removed. However it is reasonable that the patient's dignity is protected. Where possible, efforts must be taken not to disturb the scene until it has been examined by the Police on the behalf of the Coroner or until advised by the Police that it is permissible to do so.

3.2.1 Notification

All patient deaths are considered to be a reportable incident and must be notified immediately. Prior to notification of the death via Justice Health NSW Executive Group Page system, the EDCO must be advised.

The following format must be used when notifying the death via the Executive Group Page system:

- DIC or,
- If the death was expected, "expected death"
- Site (add name of institution also if hospitalised in a non Justice Health NSW facility)
- First 2 initials of first name
- First 2 initials of Surname
- MIN/CIMS Number/ MRN
- Suspected cause of death e.g. hanging in cell, terminal disease or unknown.

The Executive Group Page must not occur until the EDCO, has notified the Chief Executive and briefed him/her on the events surrounding the death.

The patient's death must be notified as a clinical incident in ims+ and the ims+ reference number recorded in the patient's health record. This must be completed as soon as possible following the death to enable the Clinical and Corporate Governance Unit to complete the Reportable Incident Brief (RIB) for submission to the CE and MoH. The following information must be included in the incident description if applicable:

- Time called to incident
- Time arrived at incident
- Description of scene
- Assessment of patient
- The last time the patient attended the health centre

- Relevant medical history
- Relevant medical treatment, including medications
- Description of all actions taken
- Other actions e.g. CPR commenced, Ambulance called etc.
- Aboriginality
- Whether the person was residing one out, two out cell etc.
- Whether the person was on remand, sentenced etc.
- Date reception screening was completed

The Clinical and Corporate Governance Unit is required to submit a RIB via ims+ to Ministry of Health (MoH) within 24 hours of the incident occurring. The RIB will only be submitted following approval by the Chief Executive.

3.2.2 Documentation

Justice Health NSW staff members in attendance must document the events surrounding the death in the patient's health record. The assessment for life extinct must be recorded and documented on JUS010.515 *Life Extinct Form*.

The assessment must contain the time and details of what actions were taken e.g. CPR commenced, or CPR not commenced because…..and provide the clinical rationale.

Document clearly the reasons for decisions made, the duration of emergency care and the reasons for terminating it.

Record any relevant clinical details of the death, either from witnesses and/or observation of the scene. This may include a description of the scene, for example:

- "Syringe found in hand"
- "Note found"
- "Patient found clothed lying on bed"
- "Patient found with sheet around neck."

In Correctional Centres and Youth Centres, CSNSW and YJNSW will contact NSW Police Officers to attend the death and act on behalf of the Coroner. In the Forensic Hospital, DNS will contact NSW Police who will attend the death and act on behalf of the Coroner.

Justice Health NSW staff members, as with members of the public, have an obligation to cooperate with the Police but at their and Justice Health NSW's convenience. The Police may request the staff of Justice Health NSW to provide a written statement. Justice Health NSW staff should not

make a statement to the police without seeking prior advice from their manager and Justice Health NSW Legal Advisor.

Justice Health NSW Legal Advisor will coordinate with the Police any required interview/statements. Where staff are contacted directly by the NSW Police or other difficulties arise, staff must contact their manager, AHNM, or Legal Advisor for further advice.

3.2.3 Health Record

Staff members must not provide any Justice Health NSW records to Police. An authorised copy of the electronic and paper health record will be provided to the Police on receipt of an order pursuant to s53 Coroners Act 2009.

Authorised copies may only be made, and provided to Police, by HIRS. The Patient Safety Manager will alert HIRS of the DIC.

The NUM or delegate must ensure that the original health record is sent to HIRS as soon as possible. Records must be sent to HIRS by same-day express courier, including weekends. Upon receipt of the original health record HIRS staff will make an authorised electronic copy of the electronic and paper record, complete and attach the *Pro forma for the Coroner* CNS509 form and create a volume within PAS to identify that a copy of the health record exists. HIRS shall provide an electronic copy to the Legal Advisor and to the Patient Safety Manager within seven days (HIRS must retain an authorised electronic copy of the health record).

3.2.4 The Commissioner's Report

In line with the Crimes (Administration of Sentences) Regulation 2014 section 291, on becoming aware that an inmate has died the Director Clinical and Corporate Governance (DCCG) as authorised by the Chief Executive (CE) will notify the Commissioner of CSNSW or Executive Director YJNSW.

For deaths within NSW privately managed correctional centres, private operators will prepare the Commissioner's Report and submit to Justice Health NSW's Commissioning Unit within five business days. Justice Health NSW CE will forward the Commissioner's report on behalf of the private operators to the Commissioner of CSNSW.

The Commissioners report will include a brief background of the person's health history, age, location, time and date of death and Aboriginality.

3.2.5 Debriefing

Debriefing must be arranged by the Nursing Unit Manager for staff directly involved with the death and may be necessary for other staff not on duty at the time. In these circumstances please refer to Justice Health NSW policy 3.045 *Employee Assistance Program*. Additionally, it may also be necessary to organise debriefing of other patients in situations where the death was witnessed or

with whom the deceased had a significant relationship. These patients are best referred to CSNSW/YJNSW welfare and psychology services for additional support and debriefing, including social work and welfare officers or psychologists in the Forensic Hospital.

3.2.6 Investigation

Investigation of deaths of Justice Health NSW patients is governed by the Ministry of Health PD2020_047 *Incident Management*.

3.2.7 Coronial Inquiry

All DIC in NSW are investigated by the Coroner. When a matter has been listed for a coronial inquiry, the Coroners Court will notify Justice Health NSW Legal Advisor. If the only witness called is the Officer In Charge (OIC), or if the witnesses being called are from CSNSW/YJNSW, and there are no witnesses from Justice Health NSW only the Legal Advisor will attend the inquest. If there are witnesses called from Justice Health NSW and/or contentious issues identified, the Legal Advisor shall brief the matter to external lawyers subject to notification to MoH. The Legal Advisor will contact the witnesses to advise that the Police will be requesting them to provide a statement and offer any necessary support.

If staff are contacted directly and are requested to appear before the Coroner, they must advise Justice Health NSW Legal Advisor and their line manager in the first instance.

A copy of the relevant health record shall be made available by Justice Health NSW Legal Advisor for staff to peruse prior to drafting a statement. Prior to providing a statement, staff will have an opportunity to seek legal assistance from their professional union/association should they so desire. If staff are not assisted by their union, they must seek assistance from Justice Health NSW Legal Advisor for support and to have their statement checked. Staff should at all times be provided with support and guidance by their line manager.

3.2.8 Open Disclosure

High level open disclosure is conducted for all Harm Score 1 incidents, and is coordinated by the Clinical and Corporate Governance Unit in accordance with the Ministry of Health PD2020_047 *Incident Management* and MoH PD2014_028 *Open Disclosure Policy.*

3.2.9 Media Interest

Some patient deaths may lead to media and/or public interest and must be managed through the Communications Unit in accordance with Justice Health NSW policy 2.018 *Media and Communications (External) Policy*.

3.2.10 More Information & Assistance

Any concerns/queries regarding DIC must be directed to Justice Health NSW Legal Advisor or Patient Safety Team in the first instance by contacting the office of the Clinical and Corporate Governance Unit on (02) 9700 3055.

4. Definition

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

Legislation	*Health Administration Act 1982* *Coroners Act 2009*
Policies, Manuals and Forms	3.045 *Employee Assistance Program* JUS010.515 *Life Extinct Form* *Forensic Hospital Procedure* *Death of a Patient*
NSW MoH Policy Directives & Guidelines	PD2014_028 *Open Disclosure* GL2021_004 *End-of-Life Care and Decision-Making – Guidelines* PD2020_047 *Incident Management* PD2021_029 *Verification of Death and Medical Certificate of Cause of Death (depending on the outcome of comment make above)* *PD2010_054 Coroners Cases and the Coroners Act 2009*

Incident Notification and Reporting of a Death