Health
Justice Health &
Forensic Mental Health Network

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Management of a Death

Policy Number 1.120

Policy Function Continuum of Care

Issue Date 22 January 2018

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 (JH&FMHN).

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 (Juvenile Justice Centres)
☒ Long Bay Hospital
☒ The Forensic Hospital

Previous Issue(s) Policy 1.120 (July 2013; April 2008)

Change Summary

- MoH PD2015_40 – Death – Verification of Death and Medical Certificate of Cause of Death, no longer applies to JH&FMHN
- MoH Life Extinct form no longer applies therefore there is a need to adapt form to become a JH&FMHN form (completed)
- Inclusion of the Forensic Hospital

TRIM Reference POLJH/1120

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

All deaths in NSW correctional and Juvenile 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 (JH&FMHN) has developed clear protocols 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 Juvenile Justice Centres and patients in the community under the care of JH&FMHN.

2. Policy Content

2.1 Mandatory Requirements

All deaths must be notified in the *Incident Information Management System* (IIMS) and given an initial Severity Assessment Code (SAC) rating of 1 (one).

All deaths must be immediately notified to JH&FMHN senior management via the executive group paging service. It is mandatory under Division 6C of the *Health Administration Act 1982* for SAC 1 clinical incidents to have an investigation utilising the Root Cause Analysis (RCA) methodology.

All deaths in NSW Correctional and Juvenile 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 RCA where required.

All deaths in NSW correctional and Juvenile 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 JH&FMHN medical officer or any other person. Attendance of the Coroner at the scene will be arranged by Corrective Services NSW (CSNSW) or Juvenile Justice NSW (JJNSW), 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 JH&FMHN policy allows for a registered nurse (RN) to assess the extinction of life and give notification to relevant authorities. The JH&FMHN JUS010.515 *Life Extinct Form* found on the JH&FMHN 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 (DDoN), Director Nursing Services (DNS) and After Hours Nurse Manager (AHNM) responsibility:

- The DDoN will notify the DNS who will then advise the Executive Director Clinical Operations (EDCO) who will brief the Chief Executive of events.
- During business hours the DNS 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 must advise JH&FMHN 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 who will then advise the EDCO who will brief the Chief Executive of events.
- The Forensic Hospital AHNM must advise JH&FMHN 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 or family members.

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 DDoN 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 IIMS and given an initial Severity Assessment Code (SAC) rating of one (1). The IIMS 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 unit attending the Daily Hospital Update Form to notify on IIMS.

- JH&FMHN staff in attendance must document their recollections of 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).

For further detailed information regarding the management of death in the Forensic Hospital, staff should refer to the Forensic Hospital Procedure *Death of a Patient*.

NSW Correctional and Juvenile Justice Centres including Long Bay Hospital:

Nurse Manager, Access and Demand responsibility:

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

After Hours Nurse Manager's (AHNM) responsibility:

- The AHNM must notify the EDCO who will contact the Chief Executive and brief them on events.
- The AHNM must advise JH&FMHN 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 IIMS and given an initial Severity Assessment Code (SAC) rating of one (1). The IIMS 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 IIMS.

- JH&FMHN staff in attendance must document their recollections of 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.
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Clinical and Corporate Governance Unit

Program Manager Patient Safety responsibility:

- To coordinate the completion of the Reportable Incident Brief (RIB).
- Determine whether a death review or a Root Cause Analysis investigation is to take place.
- Notify HIRS that a death has occurred.
- Notify Consumer Focus & Quality Officer that a death has occurred for open disclosure coordination.
- Notify Director Aboriginal Strategy and Culture of any death of an Aboriginal or Torres Strait Islander person.

Health Information and Records Service (HIRS)

- Make two authorised copies of the electronic and paper record,
- Provide copies of the health record as per section 3.2.3 of this policy.

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 JH&FMHN JUS010.515 *Life Extinct Form*. This applies even if CSNSW officers/JJNSW 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 GL2005_057 *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/JJNSW 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 JH&FMHN 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 at the scene will be arranged by CSNSW/ JJNSW 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 DIC are Coroner's cases, nothing must be done to the body or the scene after death. JH&FMHN staff must be aware that NSW Police investigations require that equipment remain in situ and must not be removed i.e. IV cannulae, 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 JH&FMHN 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 initially considered to be a SAC 1 incident and must be notified immediately. Prior to notification of the death via the JH&FMHN 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:

- "SAC 1 DIC" or,
- If the death was expected, "SAC 1 expected death"
- Site (add name of institution also if hospitalised in a non JH&FMHN 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 IIMS and the IIMS 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). 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 IIMS 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

JH&FMHN staff members in attendance must document their recollection of the events surrounding the death in the patient's health record. The assessment for life extinct must be recorded and documented on JH&FMHN 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 Juvenile Centres, CSNSW and JJNSW 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.

JH&FMHN staff members, as with members of the public, have an obligation to cooperate with the Police but at their and JH&FMHN convenience. The Police may request the staff of JH&FMHN to provide a written statement and this may take place at the police station or at the JH&FMHN site. JH&FMHN staff should not make a statement to the police the same day of the death or without seeking prior advice from their manager, JH&FMHN Legal Advisor and/or their professional union/association.

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

3.2.3 Health Record

An authorised copy of the electronic and paper health record must be given to the Police acting on behalf of the Coroner. Authorised copies may only be made by the HIRS staff. The NUM or delegate must ensure that the original health record is sent to HIRS as soon as possible for photocopying. Records must be sent to HIRS by same-day express courier, including weekends. In the event of possible delays in getting the record to HIRS for photocopying, HIRS staff may direct the centre staff to photocopy relevant sections of the most recent record to give to the Police before sending the original health record to HIRS. Upon receipt of the original health record HIRS staff will make two authorised copies 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. These two copies of the health record are provided to the CSNSW Investigation Unit or in the event the death occurs in the Forensic Hospital sent to the Coroner and to the Director Clinical Business Unit (DCBU). Authorised copies of the health record must be returned to HIRS for storage. The Clinical and Corporate Governance Unit will make further copies of the DCBU copy for the purpose of a death review and medico-legal processes. One copy of these records will be kept in the Clinical and Corporate Governance Unit until the Coroner's inquest is complete.

3.2.4 The Commissioner's Report

An initial death report will be prepared by the Manager Service Development & Quality and approved by the Chief Executive for forwarding to the Commissioner of CSNSW or Executive Director JJNSW.

The Health Record must be carefully reviewed before the report is compiled. The death report must contain a brief background of the person's health history, status and all relevant details of the care provided before the death.

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 JH&FMHN 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/JJNSW 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 JH&FMHN patients is governed by JH&FMHN policy 2.030 *Incident Management*. This policy also outlines requirements and processes for deaths in the community.

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 the JH&FMHN Legal Advisor. If the only witness called is the Officer In Charge (OIC), or if the witnesses being called are from CSNSW/JJNSW, and there are no witnesses from JH&FMHN only the Legal Advisor will attend the inquest. If there are witnesses called from JH&FMHN and/or contentious issues identified, the Legal Advisor will brief the Chief Executive to obtain approval to 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 the JH&FMHN Legal Advisor and their line manager in the first instance.

A copy of the relevant health record is available for staff to peruse prior to giving their Police statement or alternatively, the Police should have the health record available at the time. It is advisable that staff have their statement checked by their professional union/associations legal team where the matter has been referred to the union prior to signing the statement. If staff are not represented by their union, they must refer the matter to the JH&FMHN Legal Advisor for support and to have their statement checked. Staff are entitled to have a support person present when providing their statement.

3.2.8 Open Disclosure

High level open disclosure is conducted for all SAC 1 incidents, and is coordinated by the Clinical and Corporate Governance Unit in accordance with JH&FMHN policy 2.030 *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 JH&FMHN policy 2.018 *Media and Communications (External) Policy*.

3.2.10 More Information & Assistance

Any concerns/queries regarding DIC must be directed to the 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*
JH&FMHN Policies, Manuals and Forms	2.030 *Incident Management* 3.045 *Employee Assistance Program* JUS010.515 *Life Extinct Form* CNS 509 *Pro Forma for the Coroner* CNS 510 *Acknowledgement of Receipt of Health Record* *Forensic Hospital Procedure* *Death of a Patient*
NSW MoH Policy Directives & Guidelines	PD2014_028 *Open Disclosure* GL2005_057 *End-of-Life Care and Decision-Making - Guidelines*