Wellspring Recruitment and Care Services Limited
16 Patmore House, Mayville Estate, Mathias Road N16 8LQ

Review Sheet

Last Reviewed 10 Jul 2025

Last Amended 10 Jul 2025

This policy will be reviewed as needs require or at the following interval: Annual

Business Impact:	LOW — Minimal action required. Circulate information amongst relevant parties.
Reason for this Review:	Scheduled review
Changes Made:	Yes
Summary:	This policy relates to an unexpected death at the service. It has been reviewed with minor changes. References and further reading links have been checked and updated.
Relevant Legislation:	• The Care Act 2014 • Care Quality Commission (Registration) Regulations 2009 • The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Health and Safety at Work etc. Act 1974 • Mental Capacity Act 2005 • Mental Capacity Act Code of Practice • Nursing and Midwifery Council (NMC) Legislation • Coronavirus Act 2020
Underpinning Knowledge:	• Author: GOV.UK, (2025), When a Death is Reported to a Coroner [Online] Available from: https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner [Accessed: 10/07/2025] • Author: Resuscitation Council, (2025), ReSPECT [Online] Available from: https://www.resus.org.uk/respect/?assetdeta3af2d45-c6ff-4793-84c9-61858f65b520=31443 [Accessed: 10/07/2025] • Author: Bereavement Advice Centre, (2021), What to do when Someone Dies at Home or in a Care Home [Online] Available from: https://www.bereavementadvice.org/topics/what-to-do-when-someone-dies/at-home-or-in-a-care-home/ [Accessed: 10/07/2025] • Author: GOV.UK, (2024), Sudden Unexpected Death: Medical investigation [Online] Available from: https://www.gov.uk/government/publications/sudden-unexpected-death-medical-investigation [Accessed: 10/07/2025] • Author: Home Office, (2024), Dealing with Sudden Unexpected Death [Online] Available from: https://assets.publishing.service.gov.uk/media/65e5e7293f694514a303604d/2024+Police+Practice+Advice+-+Dealing+with+sudden+and+unexpected+death.pdf [Accessed: 10/07/2025]

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Suggested Action:	
Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

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1. Purpose

1.1 To outline the policy and procedure that staff are expected to follow in the event of a sudden death of the Service User.

1.2 Where there is absolutely no doubt that the Service User is deceased the following procedure must be followed. Otherwise, basic life support will be started and the Emergency Services will be called.

1.3

Key Question	Quality Statements
EFFECTIVE	QSE1: Assessing needs QSE2: Delivering evidence-based care & treatment
EFFECTIVE	QSE2: Delivering evidence-based care & treatment QSE3: How staff, teams & services work together
RESPONSIVE	QSR1: Person-centred care
RESPONSIVE	QSR7: Planning for the future

1.4 Relevant Legislation

- The Care Act 2014
- Care Quality Commission (Registration) Regulations 2009
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Health and Safety at Work etc. Act 1974
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Nursing and Midwifery Council (NMC) Legislation
- Coronavirus Act 2020

2. Scope

2.1 Roles Affected:

- All Staff

2.2 People Affected:

- Service Users

2.3 Stakeholders Affected:

- Family, friends or representatives of Service Users

3. Objectives

3.1 To ensure that staff are clear what actions they must take if the Service User is found deceased and the death is sudden or unexpected, whilst ensuring that the Service User is treated with dignity and respect.

3.2 To ensure that staff are provided with support following an unexpected or sudden death of the Service User and that the family and representatives are also supported at this time.

3.3 Identify under what circumstances the Service User's death should be investigated, the level of record keeping and who has responsibility for this.

4. Policy

4.1 The sudden death of the Service User will be dealt with in a timely, sensitive and caring manner, respecting the dignity, religious and cultural beliefs of the Service User's relatives and carers.

4.2 Wellspring Recruitment and Care Services Limited recognises it has legal, contractual and specific duties to report the deaths of Service Users to the various statutory bodies as well as other bodies.

Where relevant, it also has a duty to ensure that any untoward incidents which may have played a part in the Service User's death are not only identified and reported, but that appropriate investigations are carried out to ensure that lessons are learnt.

4.3 All staff will work co-operatively with the Emergency Services and Coroner's Office.

4.4 The Registered Manager will ensure that staff have received basic life support training and understand the procedure in the event of a sudden or unexpected death.

4.5 The Registered Manager will ensure that any Advance Directives (Living Wills), including any 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) instructions, are included with the Care Plan or kept in an agreed safe place and is shared with the relevant staff. Staff will also be trained to understand the Resuscitation Council ReSPECT process.

4.6 When the Service User's circumstances change or a review is required, the validity of the Advance Directive and/or DNACPR will be checked to ensure it is still valid.

4.7 It is standard practice to have a medical professional verify the death of the Service User. This could be a GP or paramedic, or other suitably qualified person.

Verification of death is the process of confirming the fact of death. It is different to certification of the cause of death.

Certification of the cause of death remains the responsibility of a registered medical practitioner via a medication certificate of cause of death (MCCD) that can be completed later.

Following verification of death, care after death must be performed according to the wishes of the deceased as far as is reasonably practicable.

4.8 The Registered Manager will ensure that staff understand and follow the Mental Capacity Act 2005 and comply with the Code of Practice as well as understanding the implications of the Deprivation of Liberty Safeguards.

5. Procedure

5.1 DNACPR - Do Not Attempt Cardiopulmonary Resuscitation

All staff must be aware of all times about which Service User are for active resuscitation and which Service Users have DNACPR in place. This could be by use of a handover sheet, or a discreet marker on the Service User's Care Plan or folder.

Staff will understand the importance of ensuring that Service User's wishes and preferences are recorded and shared/agreed with a medical professional when determining the actions staff must take in the event of a medical emergency.

5.2 Sudden Death Procedure

- If you discover the Service User who you think is dead, whatever the circumstances, make a note of the time
- Call the Emergency Services, ask for the Police and Ambulance. Give as much detail about the Service User's circumstances and position as possible, give directions if necessary. Follow any instructions given by the emergency services e.g. not touching the Service User. Do not leave the home
- If the Service User is for resuscitation staff should follow the Resuscitation Policy and Procedure at Wellspring Recruitment and Care Services Limited
- Try not to disturb the scene, do not touch, move or disturb anything apart from during any resuscitation attempt
- Do not remove, change or stop any medication infusions
- Do not remove or touch any life-prolonging medical equipment before the Police arrive on the scene
- Inform Wellspring Recruitment and Care Services Limited or Out of Hours as soon as possible
- Co-operate with the Emergency Services when they arrive
- Death will need to be confirmed and the Police will inform the Coroner if the death is suspicious, before the Service User's body can be removed
- Complete the incident form at Wellspring Recruitment and Care Services Limited as soon as possible

The coroner may order a postmortem examination to determine the cause of death and then issue the documents allowing the death to be registered.

The police will arrange for the body to be moved by a funeral director acting for the coroner if the death is unexpected. Funeral directors provide a service any time of day or night to move the deceased to a funeral home.

If the death involved some kind of trauma, it may require specialist cleaning services to help deal with the place where the Service User has died. There are companies that provide these services with sensitivity and discretion.

Where abuse is suspected to have played a part in the Service User's death, the senior member of staff on duty will submit a safeguarding alert at the earliest opportunity and follow the Safeguarding Adults Policy and Procedure of Wellspring Recruitment and Care Services Limited.

The staff member who witnessed the death, arrived first on the scene or who has concerns about the circumstances of the death must complete an incident and accident form before

the end of the shift and include as much detail as possible with details of any witnesses. The form must then be given to the person in charge.

Staff should refer to the Death Investigation in England and Wales flowchart in the Forms section of this policy.

5.3 Cultural, Religious or Belief Considerations

The Care Worker must be aware of any cultural, religious or belief needs of the Service User. This will be clearly documented in the Care Plan and shared with the Emergency Services.

5.4 The Registered Manager's Responsibilities

- As the Care Worker may not be able to complete the care visit record or remove it from the home, Wellspring Recruitment and Care Services Limited will need to ensure that a timeline of events is clearly recorded by asking the Care Worker to provide a detailed report. This may be required if there is a Coroner's inquest
- The Care Worker may complete a digital record in the usual way, and must be sure to add detail to the record confirming time of arrival
- Any paper care records, medication records, visit logs, Care Worker rotas etc. must be safely stored in the event that there is a request for information from the Police or Coroner
- The Police or Coroner may request access to digital care records. Wellspring Recruitment and Care Services Limited understands the requirement for this and will allow secure access as and when requested
- If the death occurred whilst the Care Worker was present or may have been a result of the regulated activity and how it was provided, the Registered Manager will need to submit a CQC Statutory Notification of Death via the Provider Portal or via email to the Care Quality Commission
- The Registered Manager will need to ensure that if the Service User's care was commissioned by the Local Authority, the Social Services Duty Team or named social worker, they are informed of the death
- Details will need to be given to the commissioner about when the service stopped
- If there are any concerns about Care Workers failing to fulfil their role, e.g. the Care Worker failed to attend, or there had been concerns about the Service User prior to their death and this was not reported and escalated, a Safeguarding Vulnerable Adults Investigation will need to be commenced. Local reporting procedures will need to be followed and a Statutory CQC Notification will need to be completed
- If the death is a Notifiable Safety Incident under the ‘Duty of Candour', the Registered Manager must notify the ‘relevant person’ about the incident and follow the Duty of Candour Policy and Procedure at Wellspring Recruitment and Care Services Limited
- The incident will be reviewed as part of the governance procedures at Wellspring Recruitment and Care Services Limited to understand if there are any lessons that can be learnt

5.5 Unable to Gain Access - No reply

- If the Care Worker arrives at the Service User's residence, cannot gain access but can see the Service User, the Emergency Services must be called
- If the Care Worker cannot see the Service User and gets a 'No Reply', the Access to People's Homes (No Reply) Policy and Procedure at Wellspring Recruitment and Care Services Limited must be followed
- The Care Worker will not leave the home until the Police have advised they can do so

- The Care Worker will inform Wellspring Recruitment and Care Services Limited to ensure that any other Service User visits are covered

5.6 Informing Relatives

- The Care Worker must not contact family, friends etc. of the deceased Service User to inform them of the unexpected or sudden death
- The Registered Manager, or if unavailable, the person in charge of the service, will first liaise with the Police and/or GP and must not inform the family without prior approval from them
- If the Local Authority is involved in the Service User's care and support, guidance should also be sought from them, where possible, before any family, relatives etc. are notified
- Once the Registered Manager or the person in charge of the service has approval to inform the family, friends etc, contact must ideally be undertaken face to face. The person informing the family, friends etc. must be suitably trained and have the knowledge to carry this out
- The Registered Manager or the person in charge must record in the deceased Service User's daily notes the date and time these calls or meeting took place
- If the Service User's death has occurred as a result of something going wrong with their care, the Registered Manager or person of sufficient seniority that this is delegated to, should explain to the family with openness and empathy what is known so far about the Service User's death, acknowledging and apologising that the event has happened, in line with the Duty of Candour policy at Wellspring Recruitment and Care Services Limited. If an investigation is to take place, the staff member should explain this and as much as is currently known about what that investigation will involve. They should offer family members the opportunity to be involved in the investigation as much or as little as they wish

5.7 Support for Staff

Staff must be given the opportunity to attend bereavement training. The Registered Manager should take into consideration the length and intensity of the professional working relationship between staff and individuals and their family/representatives when deciding whether staff can attend the funeral.

The Registered Manager should be aware that attending the funeral of the Service User may help members of staff to deal with their own feelings of grief.

The sudden or unexpected death of the Service User can be distressing and upsetting for staff. Wellspring Recruitment and Care Services Limited will endeavour to send a senior member of staff to support the Care Worker at the property as soon as possible. Arrangements for staff support following a sudden death incident will be made via the line manager.

5.8 Investigation

The system for death investigation in England and Wales essentially fits into one of four pathways (GOV.UK 2024):

- Death which is anticipated due to naturally caused ill health and where a medical doctor is able to issue a Medical Certificate of the Cause of Death (MCCD)
- Death where a doctor is unable to issue an MCCD because there is reason to suspect the death is violent or unnatural, or they have not recently attended the deceased or because the cause of death is unascertained. The case is then referred to a coroner for investigation. This will usually involve the police and a coroner’s officer, who attends the scene of the death to complete an initial

investigation on behalf of the coroner. If the outcome of that investigation is that the death is not suspicious and there is no third party involvement, the coroner will continue with the investigation. This is often assisted by the police and may involve the coroner appointing a non-forensic hospital pathologist (known as a 'histopathologist') to conduct a post-mortem examination to help determine the medical cause of death

- Non-suspicious, unnatural deaths that will need automatic referral to a coroner, for example, deaths from industrial disease, suicides or drug-related deaths
- Death where the outcome of the police investigation is that the case is suspicious (caused by a criminal act). The police then take on primacy in the investigation. In consultation with the police, the coroner will appoint a Home Office registered forensic pathologist to conduct the post-mortem examination. Normal non-forensic post-mortem examinations and forensic post-mortem examinations are very different. Therefore, if the outcome of an initial police investigation is flawed, and the decision by the police is that the case is not suspicious, there will be no forensic examination of the body and a potential homicide could be missed

For any unexpected death, staff must work with the coroner and police to establish roles and responsibilities in the investigation process.

Following the reforms to death certification from 9 September 2024:

- A medical practitioner will be eligible to be an attending practitioner and complete an MCCD, if they have attended the deceased in their lifetime
- The attending practitioner will propose a cause of death, if they can do so, to the best of their knowledge and belief
- The introduction of medical examiners will see routine, independent scrutiny of the cause of death proposed by an attending practitioner
- Attending practitioners must share the MCCD and proposed cause of death with a medical examiner, who will scrutinise these before submission to the registrar
- Under the medical examiner's regulations, medical examiners provide independent scrutiny of causes of death and will be a contact for bereaved people who wish to ask questions or raise concerns
- A new MCCD will replace the existing certificate to reflect the introduction of medical examiners, who will scrutinise the proposed cause of death

6. Definitions

6.1 Sudden Death

- **Sudden death** is any violent or unnatural death, a death where the cause is **unknown or unanticipated** and may include death that occurs under **unexplained** or **suspicious circumstances**

6.2 Unexpected Death

- **Unexpected death** is a term used when deaths occur under **unexplained** or **suspicious circumstances**

6.3 Expected Death

- An expected death is a death where the Service User's demise is anticipated in the near future

6.4 Coroner

- A coroner is a person whose role is to confirm and certify the death of an individual. A coroner may also conduct or order an inquest into the manner or cause of death, and investigate or confirm the identity of an unknown person who has been found dead within the coroner's jurisdiction

6.5 Deprivation of Liberty

- The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act 2005 allows restraint and restrictions to be used – but only if they are in a person's best interests

6.6 Advance Directive

- An advance decision (sometimes known as an Advance Decision to Refuse Treatment, an ADRT, or a Living Will) is a decision that the Service User can make to refuse a specific type of treatment at some time in the future. The purpose is that the Service User's wishes will be known if they are unable to make or communicate those decisions themselves

6.7 CQC Statutory Notification of Death

- All care providers must notify the CQC about certain changes, events and incidents affecting their service or the people who use it. This includes when the Service User dies

6.8 Duty of Candour

- Providers under the Duty of Candour have a responsibility to be open and transparent with people who use their services and other 'relevant persons'
- There is also an obligation when something goes wrong in relation to care and treatment that people are informed about the incident and provided with reasonable support and an apology, where necessary

6.9 Mental Capacity Act 2005

- The **Mental Capacity Act** 2005 (MCA) is designed to protect and empower individuals who may lack the **mental capacity** to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Examples of people who may lack **capacity** include those with dementia

6.10 ReSPECT

- ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices
- The ReSPECT process is a new approach to encourage people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices
- The ReSPECT process is intended to respect both patient preferences and clinical judgement
- The ReSPECT process provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning

7. Key Facts - Professionals

Professionals providing this service should be aware of the following:

- All staff are aware which Service Users are for active resuscitation and which have a DNRCPR in place
- Staff will work cooperatively with the emergency services and coroner's office
- Staff have received basic life support training and understand how to respond in the event of a sudden or unexpected death
- The deceased Service User will be treated with dignity and respect. However, staff must remember to try not to touch, move or disturb the scene until authorised by the Police
- Staff will not inform relatives of the sudden or unexpected death of the Service User without prior approval from the Police

8. Key Facts - People Affected by The Service

People affected by this service should be aware of the following:

- Staff will be trained to understand Advance Directives and the need to respect end of life wishes as far as possible
- Staff will be aware of any cultural, religious or belief needs

Further Reading

Care Quality Commission - Notifications:

https://www.cqc.org.uk/guidance-providers/notifications/notification-finder

Care Quality Commission - Regulation 16: Notification of Death of Service User:

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-16-notification-death-service-user

Easy Read Health (free membership) - Let's Talk About Death (Easy Read):

https://hubble-live-assets.s3.amazonaws.com/easy-health/attachment/file/154/lets-talk-about-death.pdf

Outstanding Practice

To be "outstanding" in this policy area you could provide evidence that:

- The wide understanding of the policy is enabled by proactive use of the QCS App
- Service Users' End of Life wishes are recorded clearly in the Care Plan and communicated to staff
- There is evidence that staff have been provided with support following the sudden or unexpected death of the Service User

- The sudden death of the Service User is reviewed as part of the governance processes at Wellspring Recruitment and Care Services Limited to understand any lessons learnt
- Wellspring Recruitment and Care Services Limited understands its responsibility in relation to the Duty of Candour and has a process in place for communicating with relatives openly and in a sensitive manner

Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Death investigation in England and Wales - CC84	Flowchart for death investigation in England and Wales.	GOV.UK

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suspected homicide' guidance. Figure 1 below, shows the process of a death investigation which now includes the Medical Examiners scrutiny of the MCCD.