North Wales Safeguarding Adults Board

Unexpected Death of An

Adult At Risk Protocol

Version	Revision	Date
Draft V1	For consultation	05/10/2023
V1	Ratified at Board	13/02/2024

1.0 Introduction:

The circumstances in which an unexpected death of an Adult at Risk takes place, where there is a suspicion or it is known that abuse or neglect was involved, can be challenging and complex to navigate with partner agencies having different roles and responsibilities in response to the death.

The adult death protocol provides a framework for establishing an agreed standard between partners to:

- Ensure an effective and consistent multi-agency response that will support agencies of the NWRSB to meet the requirements of legislation, national and local guidance and practice standards around appropriate responses to unexpected adult deaths involving abuse and neglect.
- Ensure clarity and consistency of procedures across organisations of the NWRSB.
- Develop arrangements that support efficiency in partnership working to identify potential criminal offences or when there is a need to conduct investigations into unexpected adult deaths.

The protocol has been developed with the aim of establishing a rapid, co-ordinated multi-agency response, and to ensure clarity and consistency across agencies. It aims to promote effective information sharing which will lead to improved outcomes in investigating unexpected adult deaths involving abuse or neglect.

2.0 Unexpected death of an adult at risk:

For the purposes of this protocol the definition used is for an adult at risk as set out in the Wales Safeguarding Procedures 2019 which sets out the legal duties and responsibilities in relation to adult safeguarding. Section 126(1) of the Social Services and Well-being (Wales) Act 2014 defines an “adult at risk” as an adult who:

a) is experiencing or is at risk of abuse or neglect.

b) has needs for care and support (whether or not the authority is meeting any of those needs).

and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The adult death protocol applies to the following criteria:

- an adult dies in unexpected or unnatural circumstances, and
- there is a suspicion, or it is known, that abuse, or neglect was a contributory factor in their death, and
- the abuse or neglect was caused by a third party.

Given that the protocol only applies in relation to these criteria, it does not apply to people who pass away due to drug-related deaths, self-neglect or suicide.

Furthermore, it will not apply in any situation involving a suspected homicide, where the homicide investigation and Domestic Homicide Review process takes precedence. If the death is due to drug or alcohol misuse, self-neglect or suicide and a third party has administered / provided the illicit substances, police investigation will have commenced, and this protocol may need to be considered with the AAR process. The protocol does not replace any internal policies and procedures of partner agencies. Staff should also refer to relevant policies and guidance of their own organisation in conjunction with this document.

3.0 Roles:

3.1 North Wales Police

Sudden, Unexpected and Suspicious Death Policy (050 review 30/1/25)

1.1 FCC Staff	• Take the initial call.
	• Create an incident log.
	• Crime Recording:
	  ○ All unexpected reports of death should be recorded on the force crime recording systems in line with Home Office Crime recording Standards.
	  ○ An unexpected death should only be recorded as a crime (notifiable offence) if it is immediately apparent that:
	  a) the circumstances of the incident amount to a crime as defined by law; and
	  b) there is no credible evidence to the contrary immediately available.
	
	Once an initial assessment has been made of the circumstances of a reported death, an appropriate level of resource must be allocated to respond. There are 4 classifications for death investigations:
	
	  ○ **Expected death**. For example, where there is a medical diagnosis, and a medical practitioner is able to sign a medical certificate of cause of death.

	○ **Unexpected death - under investigation**. Where the death was not expected, and the police investigation has not yet been able to prove or disprove there was any third-party involvement and further investigation is required. DA suicide and consideration of DHRs? ○ **Unexpected death - investigated and not suspicious**. Where the death was not expected, and the police investigation has secured evidence to indicate there is no third-party involvement. ○ **Homicide** – Where the death was not expected and the police investigation has established in all likelihood there was third party involvement, or obvious evidence of homicide
1.2 Response Officer	• Attend the scene and establish the full circumstances. • Make an informed assessment of the situation. Death to be treated as suspicious unless or until investigations reveals otherwise. • Secure and preserve evidence. • Escalate where necessary.
1.3 Response Supervisor	• Ensure supervision of the attendance. • Assess the information available and provided. • Make an informed decision on escalation or referral to CID. • In defined circumstances, supervisors can confirm death (as per 5.4.2 Preservation of life)
1.4 CID /PVPU	• Attend the scene where required by response supervisor. • Assess the information available and ascertain if the death is deemed suspicious. • Escalate to duty Det Insp and / or SIO where applicable. • **Identify if this protocol applies and contact Local Social Care Safeguarding team and Protecting Vulnerable Person Unit (PVPU) to implement this protocol.**
1.5 Det Insp	• Take on initial command and control of a death to which this policy applies. **PVPU DI Liaise with partners to ensure AUDR protocol is completed.**
1.6 SIO	• Take on the role of Senior Investigation Officer where it is deemed appropriate to do so given the circumstances of the individual case. The SIO will refer to the Major Crime Investigation Manual November 2021
1.7 Coroners Officer	• Carry out coronial duties as directed by the HM Coroner.
1.8 Force Crime Registrar	• Have oversight of all records that do not result in the recording of a confirmed crime and ensure that the appropriate classification code is applied.

3.2 WAST:

- Follow JRCALC Clinical Practice Guidelines in the management of termination of resuscitation and verification of death in adults.

- Clinical Contact Centre (CCC) notified to inform Police to attend incident as per unexpected death process.

- Complete WAST Patient Clinical Record (ePCR) and Recognition of Life Extinct (ROLE) document fully, including circumstances of event, observations at scene, conversations and decisions.

- Any safeguarding concerns identified to be reported through WAST Safeguarding process.

- WAST Safeguarding Team to be point of contact for engagement with NWRSAB Adult Unexpected Death Protocol.

3.3 BCUHB:

- Notify North Wales Police Control room, under this protocol & the AREA/ PVPU DI to be notified.
- Identify services involved with the individual.
- Secure records for that person.
- Involved service to record the incident via Datix system.
- Involved service to complete the Make it Safe process and share immediate learning within BCUHB.
- Identify an appropriate representative from the service to engage within the NWRSAB ADULT DEATH PROTOCOL**.**
- TRiM referral and occupational health support to be offered in addition to team pastoral support of individuals involved.

NOTE: There is another protocol if there is a death in the hospital North Wales Police Incident Coordination Group The purpose of the incident co-ordination group is to provide strategic oversight of a patient safety incident involving the NHS and the police, CQC and/or HSE. It is a forum for communicating, exchanging information and coordinating multiple investigations.

It allows all three organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation e.g. legal proceedings, or the phasing, extent and timing of further NHS investigations. It should be the means by which the investigating officer engages the NHS and other organisations in a potential investigation in healthcare" [SIO's Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings – Revised 2015].

https://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf

3.4 Local Authority: – *(Identify Lead Coordinator Role)*

The Lead Safeguarding Manager in the Local Authority will be notified by the Police of any unexpected death in their Local Authority area.

The Lead Safeguarding Manager for Adult Social Care: -

- Will review the need for personal case records to be locked if required.
- Will identify and delegate a Lead Coordinator to the case.
- Will notify the Head of Service of the death.
- The Lead Coordinator will liaise with other agencies and lead the coordination of information gathering within social care to be shared throughout the protocol process.
- Will ensure full liaison with the Police in the event of a suspicious death. (In which case the Police Senior Investigating Officer will decide what information is disclosed to the family/carers and how.)
- Will ensure that the risk to any others is assessed as a priority on receipt of notification of the unexpected adult at risk death.
- Will ensure that the Regional Safeguarding Adult Board's Business Unit is informed of the death.
- Will ensure that appropriate representation from Adult Social Care is present at all meetings under the protocol.
- Will ensure that any investigation or safeguarding actions for Adult Social Care which may arise during the protocol process are completed.
- Will provide information, advice and support to any social care professional who is unfamiliar with the protocol.

3.5 Care Provider:

(*Taken from Sudden Death: Step by Step Process (Haulfryn Care) – see appendices****)***

- The Registered Manager within each provider setting or agency will be the lead officer in cases of unexpected death.
- The manager will ensure that senior staff adhere to the step-by-step guide set out below in the event of an expected death.
- Paramedics attending an unexpected adult death would notify WAST Clinical Contact Centre to request police attendance. This is nothing to worry about, the

police will simply need to understand the last few days or hours, and if your provider needs advice or support, they should contact their respective management.

- When the police arrive, they will direct the provider on what should happen and when. The provider should support the police in any information gathering they need to do.

No medication should be discarded. The GP, paramedics or the police will need to see the MAR chart, be provided with an overview of the last few days and may ask about diet intake. The provider may be asked to sign the statement they have arrived at and should ensure all details are correct. Signing a statement is standard practice so the information collected can be confirmed. The provider should then write up their own statement and leave this for management. It should echo the details provided to the police. Where duplicate copies of care planning etc. are given to police, please ensure that a copy is also made for management.

- The police officer will arrange for the body to be collected by the undertaker.
- Ensure date and time of death is recorded within personal plan and handover book.
- Ensure the room is clean and tidy, domestic staff will complete deep clean the following day, unless required earlier.
- Management will arrange for their notifications to be completed on the next working day.
- 'Post death Self Audit' will be completed on the next working day.

If at any point advice is needed from management, please do not hesitate to contact at any time.

4.0 Information Sharing Meeting:

The Unexpected Adult Death protocol timeline involves three potential phases:

Phase one (usually 0-5 days): The management of information sharing, including the Information Sharing and Planning Meeting, from the point at which the adult's death becomes known to any agency until the initial post mortem examination has been completed.

Information Sharing and Planning Meeting:

(Initial Information Sharing and Planning Meeting template - Appendix 1)

The meeting will be Chaired by North Wales Police with minute taking support provided by the local authority safeguarding team.

The purpose of the Information Sharing and Planning Meeting is:

- Ensure rapid information sharing and risk assessment (including risk to others).
- Confirm who will be the lead agency.
- Consider any other agencies involved and request information from them.
- Consider any other relevant enquiry or investigatory process and the timing of the same, including further police investigations, Section 26 safeguarding enquiry, Serious Incident Review, Safeguarding Adults Review (SAR).
- Considerations around family members and carers, including views of others and how family or carers will be kept informed.
- Develop a multi-agency action plan with agreed timescales and details of who is leading on each action.
- Consider actions required regarding a media strategy.
- Confirm a communications strategy across senior agency representatives.
- To determine which professional is the most appropriate person to be the single point of contact for supporting the family.
- To ensure appropriate support is provided to the family.
- For each agency to share information from previous knowledge of the adults and records, with particular reference to the environment and circumstances of the death. This would include details of previous or ongoing safeguarding concerns, history of previous unexplained injury, abuse, or neglect, previous unexplained or unusual deaths in the family, medical conditions including any disability, substance misuse, mental ill health, domestic abuse, criminal convictions, previous hospitalisation and General Practice visits.
- To collate all relevant information to share with the HM Coroner and Pathologist prior to the post mortem examination.
- To plan and determine the process of the investigation.
- To enable consideration of any safeguarding risks to any others, and to consider the need for safeguarding procedures.
- To consider the need for referral to the Regional Safeguarding Adult Board for consideration of an Adult Practice Review.

- To ensure appropriate support is provided to all professionals who attended the adult.
- To consider and plan for any media interest in the death.
- To agree who will have responsibility for any actions agreed and by when.
- To make arrangements to convene the Case Discussion Meeting within five to twenty-eight days if required.

Dependent on the information received, progression to Phase two and/or three will be unlikely, but if required then must proceed within agreed timescale and actions:

Phase two (5-28 days): The management of information sharing, including the Case Discussion Meeting, once the preliminary results of the post mortem examination are available.

Phase three (within 12 months): The management of information sharing, including the Case Review Meeting, when the final Post Mortem Report is available.

In principle it is recognised that all information relevant to the enquiry should be shared by all agencies. However, the Police and HM Coroner may consider certain information Sub Jud ice (i.e. under judicial consideration and therefore prohibited from public discussion elsewhere) or subject to continuing investigation which may preclude it being shared. In some circumstances this may include the preliminary and final results of the post mortem examination.

In these cases, the amount of information released from the Police investigation to these meetings must be sufficient to inform on the relevant issues. In particular, information shared must have regard to the welfare of other adults at risk. Any decision not to share information will be recorded by the Police Senior Investigating Officer in the Police Policy Book.

The Local Authority are responsible for ensuring that accurate minutes of every meeting are recorded, all decisions are documented and that the minutes are distributed to all invitees within 5 working days of the meeting It is not usual practice to share meeting minutes. The decision to share minutes will be at the discretion of the Information Sharing and Planning meeting attendees who will be able to consider any necessary restrictions, given the circumstances of the case and the extent of any criminal or coronial investigations, which may be prejudiced by disclosure at that stage.

5.0 Post mortem & Coroner:

North Wales Coroner's Office team working for the coroner – ascertain if a cause of death can be provided and to enable the NOK to register the death. If a cause of death unascertained the coroner may decide a post mortem is required.

Where necessary a post-mortem examination may be directed by the coroner. There are two types of post-mortem, a standard post-mortem, which would normally occur when there are no suspicious circumstances, and a home office post-mortem where there are deemed to be suspicions or concerns around the death. This is to be carried out by a forensically trained pathologist.

A home office post-mortem will only be carried out with the authority of the coroner in consultation with the Senior Investigating Officer. The coroners' officers will facilitate informing the NOK of this and the results. The coroner has oversight of all cases Via the Coroner's Office and CIVICA System.

6.0 Supporting:

6.1 Families

When an adult has died unexpectedly and in suspicious circumstances, effective and appropriate communication with families is of the upmost importance and should be carried out in a respectful and sensitive manner.

In the vast majority of cases where someone dies unexpectedly, nothing unlawful has taken place. It must also be acknowledged, however, that in a small percentage of situations something unlawful may have taken place. This must not be forgotten. Safeguarding adults is everyone's responsibility. Providing support and care to the bereaved family from the earliest possible stage is a core component of the joint agency response and runs through all stages of the response.

It is likely that the family of the deceased will be distressed and shocked. At all times consideration should be given to the family's wishes and beliefs, and how these can be accommodated within any statutory requirements. It is every family's right to have their loved one's death properly investigated. Families desperately want to know what happened, how the event could have occurred, what the cause of death was and whether it could have been prevented.

In the initial stages following the identification of an unexpected adult death, the police and coroner's officer will be the main point of contact for family members.

At the Initial Joint Agency Meeting (IJAM), responsibility as to which lead agency should provide ongoing information and coordinate appropriate care and support for the family will be confirmed. Key considerations include:

- It is important to clearly explain the process and what is happening to family members, and provide facilities to contact friends, other family members and cultural or religious support.

- Professionals should express empathy with the family and respectfully use the deceased's name and correct gender in all conversations. Sharing our humanity can make a real difference to families. Taking a trauma-informed approach to supporting family members, is key to managing wellbeing and preventing traumatisation.

- Consideration should be given to the capacity of the family to engage in the processes unfolding around them. Support from advocacy services should be considered where appropriate. Particular consideration should be given to issues of language, health or mental capacity. Further consideration must also be given to the faith and culture of the deceased and their family.

- Where English is not the family's first language, every attempt should be made to provide a translation or interpreting service, including out-of-hours provision, for 11 example through Language Line. Family members, particularly children, should not act as interpreters.

- Responsibility for providing ongoing information and coordinating appropriate care and support for the family is shared between the lead health or social care professional, police investigator and coroner's officer. There needs to be clear liaison between these professionals as to who will take responsibility for each aspect of care and support.

- The family should be told at an early stage that, because their loved one's death was unexpected, the coroner will need to be informed and there will need to be a police investigation. This must be explained to the family in a sensitive way, emphasising that these are routine procedures that are followed for an unexpected adult death.

- The purpose and process of the joint agency response should be explained to the family, emphasising that all professionals are working together to try to help them understand why their loved one has died and to support them. The family should be informed that, as part of this process, information will be shared with their primary care team, social services and other relevant professionals.

- The family should be informed that the coroner is likely to order a post-mortem examination. The family should be informed about the post-mortem examination, including the likely venue and timing, any arrangements for moving their loved one, and the likelihood that tissues will be retained during the post-mortem examination. This information should be provided in a sensitive and meaningful manner.

- As part of the explanation about the post-mortem examination given to the family, the lead health or social care professional or coroner's officer should explain that tissue samples will be taken and that, following the coroner's investigation, the family can then determine the fate of the tissue according to the Human Tissue Act 2004.

- The family should be made aware that it may take several weeks to secure the results of the post-mortem examination and for the coroner to come to a conclusion. Every effort should be made to keep the family informed at each stage of the process. The family should receive regular telephone calls from either the health or social care professional supporting the family or the coroner's office to let them know how matters are proceeding.

- The family should be clearly informed of the names and contact details of the lead professionals responsible for the joint agency response, including the lead health or social care professional, police investigator and coroner's officer. If it becomes necessary to transfer responsibilities between professionals, the family should be informed of this and introduced to any new professionals involved.

- The family must be given clear details of whom to contact, both in working hours and out-of-hours, should they have any questions or concerns.

- Under the Police and Criminal Evidence Act 1984, section 29, if the police investigator has suspicions that the death may be a crime, the law demands that the suspect's rights are protected and certain legal restrictions apply in terms of how they can be spoken to, and by whom. This is particularly relevant where the possible suspect is a family member.

6.2 Staff Welfare & Wellbeing:

Adult at risk deaths will have varying degrees of impact upon staff. Line Manager's responsible for all staff involved in the Protocol Response to Unexpected Deaths in Adults at risk should ensure a de-brief is undertaken, for the purpose of welfare and wellbeing, prior to the staff member going off duty and provide appropriate support as required.

Please refer to: The North Wales Protocol for the Support of Employees Affected by Critical Incidents

7.0 Appendices:

7.1 Relevant Documentation:

Information sharing template:

Appendix J – Initial Information Sharing a

Haulfryn Care Ltd. process

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7.2 Bereavement Services / Helplines / Information:

Dewis Wales	https://www.dewis.wales/bereavement
Cruse UK	https://www.cruse.org.uk/
Diverse Cymru	https://diversecymru.org.uk/wales-bereavement-information-and-support-service/
At a Loss	https://www.ataloss.org/
The Good Grief Trust	https://www.thegoodgrieftrust.org/

7.3 Information about Safeguarding & Safeguarding Reviews:

North Wales Safeguarding Board:

https://www.northwalessafeguardingboard.wales/

Single Unified Safeguarding Review:

https://www.gov.wales/single-unified-safeguarding-review-guidance

7.4 Coroner Information:

When a death is reported to a Coroner:

https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

Coroner's Courts & Tribunals:

https://www.judiciary.uk/courts-and-tribunals/coroners-courts/coroners/

7.5 Flowchart:

Overview of Adult Death Protocol (ADP)

IMMEDIATELY

Unexpected adult death in which ADP criteria are indicated identified by an agency.

- The identifying agency contacts North Wales Police Centre via 101 to make a referral for the ADP to be triggered.
- The contact centre conducts initial triage to identify if ADP criteria are met.
- The contact centre notifies first line police responders to attend location of body.

Ambulance and Police attend location of the body.

- Health professional / clinician confirms death.
- First line responders draw on professional judgement and use ADP aide memoir. If they suspect abuse or neglect by a third party, a Detective Sergeant (DS) attends and conducts initial investigative assessment.
- If DS believes ADP criteria are met, a Detective Inspector (DI) Crime Scene Investigators (CSI) and the Coroners Officer attend and conduct a joint examination of the body with the attending medical practitioner.
- Consider safeguarding risk to other adults and / or children and raise a safeguarding concern if required.
- Engage staff / family and explain ADP process.
- If a homicide is suspected, then the homicide process takes primacy.

Attending DI notifies MASH DI to arrange Initial Joint Agency Meeting (IJAM)

IJAM to have representation from statutory partners i.e.

- North Wales Police
- BCUHB Safeguarding Team
- Adult Social Care

WITHIN 24 HOURS

IJAM chaired by MASH DI

- Initial information sharing, risk assessment, action plan (including consideration of risk to other adults / children)
- DI and health practitioner / clinician confirms case meets ADP.
- Confirm lead agency.
- Consider involvement from any other relevant agency and plan to request additional information.
- Confirm other enquiry / investigation processes.
- Consider if the criteria for an APR referral may be indicated.

WITHIN 6 WEEKS

Police

Investigation into potential criminal offences

Coroner

Preliminary and final post-mortem examination report provided to the coroner and with coroner's agreement to the police.

Any other enquiry or investigatory process

Review of health and social care information

Actions undertaken following meeting.

- Agencies follow own internal processes to review the circumstances of the death.
- Appropriate feedback of outcomes of local case discussion to family and interested

Follow up meeting to be arranged by lead agency if appropriate.

- Learning from the case
- Confirm any further case management actions.
- Strategic recommendations

***Note*: Any recommendations made at this meeting are the responsibility of the owning agency to progress.**

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North Wales Police

Adult At Risk Death APR

Templates for Meetings

Meeting 1

Initial Information Sharing and Planning Meeting

Vs 2 26 07 18

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
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MEETING 1: INITIAL INFORMATION SHARING AND PLANNING MEETING

Name of Adult at Risk	
Date of birth:	
Date of death:	
Address:	

Date of meeting:	
Time:	
Location:	
Chairperson:	
Minute-taker:	

- Introduction from Chair
- Apologies:

Purposes of the case discussion meeting

1. **Share all available relevant information.**
2. **Decide whether or not there are immediate Adult at Risk concerns.**
3. **To arrange, signposting ,support and counselling for those affected.**
4. **If there are other AAR involved – to discuss their needs.**

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Purposes of the case discussion meeting cont.

5. **To consider and plan for any media interest**
6. **To consider welfare/support needs of the staff involved in the response to this incident.**
7. **To consider whether the case should be considered for SUSR.**
8. **To make arrangements to convene a further Case Discussion Meeting within 5 – 28 days**

AAR details.
Name
Age
Address
Order / legal framework

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Details of family members / NOK / contacts :

_____

_____

_____

<u>Circumstances of the event:</u>

Below are the organisations/personnel who are commonly involved in the acute response to a report of an Adult Unexpected death An appropriate member of the

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meeting from each organisation should inform the meeting in detail of the circumstances of their attendance and any relevant information (inc timings, staff in attendance, circumstances as witnessed, events relayed by others etc).

1. Ambulance Service

2. Police Service

3. ED department

4. Health Consultant

5. Other

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Background Information:

An appropriate member of the meeting from each of the below organisations should outline any relevant history from their research of the contact/information held in relation to those involved in this incident.

1. Social Services

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2. Police

3. Health

4. Education / Work

5. Other

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Date/Time/Location of Post Mortem Examination:

Cause of Death
Outcome

Summary against objectives:

1. **Has all information been shared?**
2. **Are there any immediate AAR concerns?**
3. **What signposting / support/ counselling has been offered / provided?**
4. **Have other adults at risk been identified and their needs explored?**
5. **Have any staff-welfare needs been appropriately addressed?**
6. **Should the case proceed to SUSR Meeting?**
7. **Media interest?**

Actions:

No.	Action	Person responsible	Target time/date
1			
2			
3			
4			
5			

Date and time of Case Discussion Meeting (5-28 days):

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1.0 Scope

This document describes the actions to be taken in the event of a sudden or unexpected death of a person whilst living at Haulfryn.

When a GP has not been to see a person within the last three days, this is classed as a sudden death. Please follow the below process, again any advice, support or reassurance required please do not hesitate to contact management.

2.0 Responsibility

The manager will ensure that senior staff adhere to the step-by-step guide set out below in the event of an expected death.

All team members should be able to use this document as a guide as to what to expect following an unexpected death, and what would be expected of them.

3.0 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

A person may decide that they do not wish for resuscitation to be performed for them, for those who have made this decision there will be a DNACPR put into place by the GP. This will be signalled on each person's door by a discreet red dot, on their personal plans with a red dot on the outside of the folder and on the PCS handsets as a risk to be aware of. The DNACPR's will be stored in each person's Personal Plan – this will need to be shown to any attending paramedics, GP's or nurses who attend in an emergency.

3.0 Step by Step Process

Upon finding a person who is suspected to have died, when it is unexpected:

- Alert must be made to at least one other team member. First aid training should be followed, and CPR should be started, where there is no DNACPR in place. 999 should be immediately contacted by the other team member.
- The body should not be moved, unless in extreme circumstances, this should only be authorised by management.
- The family should be notified as soon as possible.

- Should there be a safeguarding concern, management should be notified as soon as possible. Team members should follow their Safeguarding training, remembering if in doubt to raise with management.
- The paramedics will inform the local police liaison officer from the coroner's office, who will come to the home to assist certify the death. This is nothing to worry about, they will simply need to understand the last few days or hours, again if you feel you need advice or support please do not hesitate to call management.
- When the police arrive, they will direct us on what should happen and when. We should support the police in any information gathering they need to do.
- No medication should be discarded. The GP, paramedics or the police will need to see the MAR chart, be provided with an overview of the last few days and may ask about diet intake. You may be asked to sign the statement they have arrived at, please ensure all details are correct. Signing a statement is standard practice so the information collected can be confirmed. Please write up your own statement and leave for management, to echo the details provided to the police. Where duplicate copies of care planning etc are given to police, please ensure that a copy is also made for management.
- The police officer will arrange for the body to be collected by the undertaker.
- Ensure date and time of death is recorded within personal plan and handover book.
- Ensure the room is clean and tidy, domestic staff will complete deep clean the following day, unless required earlier.
- Management will arrange for their notifications to be completed on the next working day.
- 'Post death Self Audit' will be completed on the next working day.

If at any point advice is needed from management, please do not hesitate to contact at any time.