Discovery of a Deceased Person Policy

Adult Social Care

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Discovery of a Deceased Person

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Division & Service:	Adult Social Care		
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Policy Owner Signatories

Name	Title/Role	Signature	Organisation	Date
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CQC Assurance Key Areas:

This policy document supports CQC Assurance Key Areas (detailed in section 7):

Safe	Effective	Caring	Responsive	Well-led
●	●	●	●	●

This document is not controlled when printed.

It is the responsibility of every individual to ensure that they are working to the most current version of this document.

Contents

1. Introduction

1.1 This policy sets out the actions that adult social care staff within Community Assessment and Care & Support Services should follow if they discover a person has died in their own home/care home.

1.2 It applies to all people in receipt of adult social care in Central Bedfordshire.

2. Legislation and Regulatory Framework

2.1 Relevant legislation:

- The Care Act 2014
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Regulation 9: Person-centred care
- The Care Quality Commission (Registration and Membership) (Amendment) Regulations 2012
- Care and Support Statutory Guidance.
- Care Quality Commission (Registration) Regulations 2009, Regulation 16: Notification of Death of a Person Who Uses Services
- Equality Act 2010
- UKHCA Infection Prevention Control Guidance

3. Principles of the Policy

3.1 This document is written in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and adheres to the fundamental standards set out by the Care Quality Commission.

- Regulation 9 of the Health and Social Care Act requires service providers to ensure that the care and treatment of people using services must be appropriate, must meet their needs and must reflect their preferences, including at the time of their death.
- Regulation 16: Notification of Death of a Person Who Uses Services - A registered person (provider or manager) must send notifications about deaths of a person using services, where the deaths occur during the carrying out of the service or in connection with it

3.2 Individuals will be assured that at the time of death staff will treat them and their representatives/advocates with care, sensitivity, dignity and respect and all deaths should be managed in a dignified way.

Cultural and Spiritual Care After Death

3.3 Staff should actively consider the deceased's religious and spiritual background. Where possible, they should refer to any documented end-of-life preferences or care plans (e.g. Advance Care Plans, ReSPECT forms). Staff are encouraged to engage with family members or spiritual advisors to ensure any reasonable cultural or religious needs are met, provided this does not conflict with legal or health and safety requirements.

Definitions:

Expected death – a death following on from a period of illness that has been identified as terminal and where no active intervention to prolong life is ongoing. The patients GP/Doctor will have been attending regularly to provide medical support

Unexpected death and /or suspicious death – where death has not been an expected outcome, for example, heart attack or unexplained circumstances.

Community Assessment Service - This service is people who find themselves needing information or assistance from adult social care; this could be new enquiries or people who are already receiving support. This includes social care practitioners, occupational therapists etc.

Care and Support Services – for the purposes of this policy this includes regulated services that including supported living, reablement, and residential care homes.

4. If a staff member discovers someone they believe is deceased

If the person was at home

Expected death

4.1 If a member of staff should discover a person who they think has died at home, and the death was **expected**, they should immediately call 111 out of hours to request confirmation of the death, and follow any instructions given; if available, press the emergency button/community alarm for support.

4.2 Verification of death must only be performed by a registered healthcare professional (e.g. a nurse) who has been specifically trained and deemed competent in line with local and national policy. This is distinct from certification of death, which is carried out by a doctor.

4.3 Staff must inform the senior colleague, who will contact the next of kin (as per the care and support plan arrangements) with empathy and privacy, allowing time for questions and, if appropriate, time with the deceased.

4.4 Do not move the person or touch any of their belongings unless it is to make a potential hazard safe (e.g. switching off a cooker).

4.5 The staff member may be required to make a statement. It is not the responsibility of the staff member to contact relatives, this will be undertaken by an appropriate manager.

Unexpected Death

4.6 If a member of staff should discover a person who they think has died, and the death was unexpected, they should make a note of the time and press the emergency button/community alarm for support (if available)

4.7 Call the police and ambulance services by dialling 999.

4.8 The operator will provide instructions on what they need to do including establishing whether the staff member can try to resuscitate the person.

4.9 The paramedics, upon arrival, will either attempt resuscitation or confirm the death.

4.10 The staff member should phone the relevant manager, or emergency duty team if the discovery occurs out of hours and agree with the police who will take responsibility for contacting the next of kin/emergency contact.

4.11 The staff member should not move the person or touch any of their possessions unless it is to make a potential hazard safe e.g. turning off the cooker. They should try to avoid touching anything else as this may disturb potential forensic evidence.

4.12 The member of staff should not leave the address until told to do so by the professional person

If the person was in a care home

Expected death

4.13 If the death was expected, perhaps due to a terminal illness, the death will need to be verified by a medical practitioner, the GP/out of hours GP should be contacted. Verification of death must only be performed by a registered healthcare professional

4.14 Staff must inform the senior colleague, who will contact the next of kin (as per the care and support plan arrangements) with empathy and privacy, allowing time for questions and, if appropriate, time with the deceased.

4.15 If the death has been expected or the GP has seen the person in the last 14 days and if the doctor can certify the cause of death, he or she will issue the home manager with:

- a medical certificate that shows the cause of death (this will be in a sealed envelope addressed to the registrar)
- a formal notice that states that the doctor has signed the medical certificate and tells you how to go about registering the death.

Unexpected Death

4.16 If the death is sudden or of unknown causes, and the person has not been seen by a GP for 14 days or more, the person's GP or registrar will inform the coroner's office and the person should not be moved until the coroner has been notified.

In both situations

4.17 In the interest of privacy and dignity and particularly if instructed by the police or the manager, the staff member should try to ensure that only people who have an actual need to approach the person, their room and belongings have access to do so. Staff should not attempt to enforce this if they feel their own safety is at risk.

4.18 The staff member should try to ensure that next of kin/representatives are as supported as much as possible. The next of kin or representatives should be informed of the death with empathy, honesty, and privacy. Staff should give the family time to ask questions and, where appropriate, offer them the opportunity to spend time with the deceased. If there are cultural or language barriers, interpreters or spiritual leaders may be engaged. Written information about what to expect next (e.g. coronial involvement, registering the death) should be available.

4.19 The discovery of a deceased person can be distressing for staff. Managers should offer an immediate wellbeing check and encourage attendance at a debrief. Where appropriate,

signpost staff to employee assistance services or external counselling. Peer support within teams should also be encouraged to process any emotional or psychological impact.

4.20 The person should complete an incident form and update notes before leaving work and ensure these are made available to the manager. (Accident, incident and near miss reporting and investigation form).

Recording

4.21 All actions following the discovery of death—such as emergency contacts, involvement of police or coroners, communication with family, and personal care—must be accurately recorded in the care records. These records must be accessible to managers and regulatory bodies if needed.

Notifications

4.22 Provider services (Care and Support) must notify CQC as soon as possible (regulation 16). The registered manager of the service should do this via the CQC Provider Portal or using the Statutory notification: Death of a person using the service form.

4.23 Provider services (Care and Support) must notify the DoLS team where a person dies who is subject to an active dols authorisation. Contact can be made via the email address: dols@centralbedfordshire.gov.uk

5. Personal Care After Death

5.1. Where the death has been verified and is not under investigation by the coroner or police, staff may carry out personal care for the deceased. This should be done within 2–4 hours of death, following Infection Prevention and Control (IPC) standards. Care may include washing the body, brushing hair, replacing dentures, dressing the deceased, and making the environment tidy. The deceased must always be treated with dignity and in line with their known preferences or cultural norms – see Personal Care After Death Policy and Procedure.

6. Infection Control Guidance

6.1. All deceased persons should be treated as potentially carrying transmissible infections such as COVID-19, tuberculosis, or bloodborne viruses. Staff must check the individual's care records for any known infection history to inform risk assessment and necessary precautions.

6.2. Before approaching the deceased, staff must wear appropriate personal protective equipment (PPE), including gloves, apron, and a mask—FFP3 if there is a suspected aerosol risk. Eye protection should be worn if there is a possibility of splashes or contact with bodily fluids. When handling the body, avoid direct contact with bodily fluids, use disposable absorbent materials if fluids are present, and ensure contaminated waste is safely disposed of following hazardous waste protocols.

6.3. Once the deceased has been removed, the area must be thoroughly cleaned and disinfected using approved agents effective against infectious pathogens, in line with local infection control guidelines. All contaminated PPE and waste materials must be treated as clinical waste and disposed of in accordance with local and national regulations. Further details can

be found in the Adult Social Care Infection Control Manuals, specifically the section on Care of the Deceased.

7. Equality and Diversity

7.1. All Adult Social Care policies are accompanied by an EIA (where applicable) and an implementation plan that sets out monitoring and reporting arrangements available in relation to this policy if required.

7.2. The Council will be proactive about putting in place arrangements to ensure that they do not unfairly discriminate against individuals on the grounds of their protected characteristics. Equality should be integral to the way in which any support is prioritised and delivered.

8. Related Policies

- Infection Prevention Control
- Personal Care After Death
- No Response policy
- Lone Working
- Staff wellbeing
- End of Life Care

9. Monitoring and Reporting Arrangements

CQC Assurance Key Questions and Quality Statements

9.1. This policy document supports CQC Assurance Key Questions and Quality Statements:

Key question:	**Quality statements we will use to assess quality**
Safe	**Learning culture** We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learnt to continually identify and embed good practices. **Safeguarding** We collaborate with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately. **Safe environments** We detect and control potential risks in the care environment. We make sure that the equipment, facilities, and technology support the delivery of safe care. **Safe and effective staffing** We make sure there are enough qualified, skilled, and experienced people, who

	receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs. **Infection prevention and control** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
Effective	**Assessing needs** We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing, and communication needs with them. **Consent to care and treatment** We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.
Caring	**Treating people as individuals** We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics. **Independence, choice and control** We promote people's independence, so they know their rights and have choice and control over their own care, treatment, and wellbeing. **Responding to people's immediate needs** We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern, or distress.
Responsive	**Person Centred Care** People's care plans fully reflect their physical, mental, emotional and social needs, including those related to protected characteristics under the Equality Act. People who use services and those close to them (including carers and dependents) are regularly involved in planning and making shared decisions about their care and treatment, so it is centred around them and their needs.
Well-led	**Governance, management, and sustainability** We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment, and support. We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate.

10. Evaluation and Review

10.1. This document will be reviewed every 2 years unless statutory guidance changes where a review will take place sooner.