Community Mental Health - Unexpected Death of a Client - Service Reporting and Support Procedure

Effective: 15 October 2018

1. Guiding Principles

Staff are advised of client death in a number of ways. This can be formally through other agencies such as hospitals, general practitioners (GPs) or police or informally through the media or word of mouth. It is important that the death is formally reported and that both the client's family and staff involved, are offered and receive appropriate support.

2. Procedure

- On discovery of a client death clinicians are to take appropriate action.
- Support is to be offered to the families and significant others as soon as possible.
- Post intervention support is to be organised for the treating team and other staff members to facilitate the resolution of the grief, loss and trauma that are likely to be precipitated by a death.
- The death of an Aboriginal client is to be responded to in a culturally appropriate manner.
- If required, open disclosure is to occur in accordance with the Australian Open Disclosure Framework. This process is to be monitored and altered accordingly to maximise effectiveness.

When an unexpected death of a client occurs, it is likely to constitute a coronial inquiry, as per the *Coroner's Act 1996*.

On being informed of an unexpected death of a client, the following people are to be notified:

- The Clinical Director
- The Regional Manager
- The Consultant Psychiatrist
- Local police – if this has not already occurred
  (The local police are then responsible for notifying Coronial Inquiry – 24 hours (9622 0260. Coronial Inquiry is part of the Police Service who assist the Perth Coroner in the investigations of deaths and fires in Western Australia).

While the police are required to formally notify relatives, this may also be undertaken by the Wheatbelt Mental Health Service (WMHS) according to the situation.

All care must be taken to preserve the dignity of the deceased while minimising distress to the client's relatives.

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Grieving within Aboriginal culture includes a whole of community response. There is a particular risk of contagion effects at the time of any Aboriginal suicide. For all deaths of Aboriginal clients or their immediate family members, consultation with the Coordinator Aboriginal Mental Health Program is required.

Notification

Information about the unexpected death of an active or past client might reach the service in a variety of ways. It is expected that the Clinical Director of the service or their delegate (the Regional Manager) be advised of the death immediately (within practical limits) when it becomes known.

Except in exceptional circumstances, no staff member other than the Clinical Director or delegate should assume responsibility for informing the affected clinician without prior discussion with the Clinical Director.

It is recognised that at times, a client death might occur when the Case Manager / Clinician is on leave. In the absence of any clear contrary direction, the Clinical Director and their delegate will maintain the boundary that the clinician is on leave, and their right to privacy and freedom from work responsibilities during leave is a primary right that needs to be preserved.

3. Roles and Responsibilities

- The Clinical Director or delegate is responsible for reporting the event to the Office of the Chief Psychiatrist and Medical Director WACHS Wheatbelt Regional Office using the appropriate form. See OD 0635/15 Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.
- The Clinical Director is to decide if the event constitutes a sentinel event. See the Wheatbelt Clinical Incident Management intranet page.

The **Clinical Director or Delegate (Regional Manager)** is to:

- assume responsibility for advising the Clinician / Case Manager of the client's death if the clinician does not already have knowledge of this
- provide immediate support to the clinician, negotiate their immediate support needs
- clarify the known facts about the circumstances surrounding the client's death
- assume responsibility for advising other staff / program members within 24 hours
- communicate reasonably established facts as appropriate
- identify other staffs' immediate support needs
- negotiate with the clinician who should inform other persons / agencies in the client's system of care
- establish a variety of supportive environments for the individual clinician and other members of clinical team to debrief, to receive accurate and updated information and to process the full range and intensity of affective responses to the client's death

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- monitor in conjunction with line manager and the clinician, the impact on the individual clinician's professional practice and their capacities within their professional role, and to identify any additional support needs that might need to be introduced to assist the clinician. These support needs might include:
  - some brief special leave (up to three days)
  - increased clinical supervision
  - joint meetings between clinician, line manager and clinical supervisor
  - cultural supervision from Aboriginal and Torr3s Strait Islander (ATSI) practitioners
  - changed or varied duties for a period of time
  - some consideration in the allocation of new clients
  - support to attend any culturally sanctioned rituals or practices e.g. attendance at funerals or "sorry business".

The **Program Coordinator** is to:

- support the clinician to acknowledge and explore the grief, loss doubts, anxieties and responsibilities associated with the client's death, and to explore the meaning and impact of this on their professional identity, professional practice and sense of themselves
- collaborate with the clinician, their line manager and Clinical Director to establish a support plan to address the clinician's needs and to manage their professional and organisational roles and responsibilities including increased supervision as agreed and negotiated
- support the clinician in understanding and participating with honesty and integrity in any team debriefing processes
- assist the clinician to understanding the importance and value of participating in internal and external reviews, audits and investigative processes in the context of commitment to learning at an individual, team and systemic level
- monitor in conjunction with Clinical Director and the clinician, the impact on the individual clinician's professional practice and their capacities within their professional role
- ensure appropriate support for family and carers is in place.

The **clinician** is to:

- complete the Datix Clinical Incident Management System (Datix CIMS) form
- complete the report to the Chief Psychiatrist online
- record the death in the Client Record and sign
- assume personal responsibility for articulating and making explicit their own support needs and to utilise all available supports with honesty and integrity
- participate as required in clinical reviews, audits and investigative processes in the context of commitment to learning at an individual, team and systemic level
- reflect and monitor the impact of the death on their professional practice and their capacities within their professional role. Use clinical and organisational supervision to explore this. Cooperate with clinical supervisor and Clinical Director to develop a support plan to address any identified needs.

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Other Team Members are to:

- offer support to affected peers and managers while balancing and respecting the affected clinician's needs for autonomy and control of their own support needs
- reflect and observe the impact of the death on their own thinking and feeling, and identify any potential impact on their own professional practice and their capacities within their professional role. Use clinical and organisational supervision and team debriefing processes to assist in this reflection
- participate in team debriefing and other meetings as required with honesty and integrity.

4. Release of Client Records

The Client Record must be released to the police or Court when appropriate documentation is produced. The Medical Director is responsible for realising medical records. A receipt should be dated and signed. Records are maintained at the Regional Director's office.

5. Clinical Review

The service and its staff have an obligation to recognise the value of internal and external reviews of serious clinical incidents, including death of a known client, and to encourage a culture where staff can participate in these in a transparent and honest manner recognising that these processes can provide valuable learning opportunities to improve individual and team practice.

6. Ongoing Clinician Support

The Program Coordinator is to ensure staff are aware of the services provided through the Employee Assistance Scheme.

This document can be made available in alternative formats on request for a person with a disability

Contact:	Regional Manager Mental Health (C.Stillian)		
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