

**Statutory notification**

Regulations 16 and 20, Care Quality Commission (Registration) Regulations 2009

Death of a person using the service

The end of the

|  |  |  |
| --- | --- | --- |
| logo | Provider’s notification reference: |  |
|       |
|  |

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| --- |
| Statutory notification about the death of a person who used the serviceCare Quality Commission (Registration) Regulations 2009 Regulations 16 and 20 |

Please read our **guidance for providers about statutory notifications** and our **Guidance about compliance: Essential standards of quality and safety** for detailed advice on how and when to make statutory notifications. This guidance is available at [www.cqc.org.uk](http://www.cqc.org.uk).

You must provide information in the mandatory sections (marked\*). Please also provide all other requested information, and **enter dates** in the format dd/mm/yyyy.

Return the completed form to: **HSCA\_notifications@cqc.org.uk**

**1. The provider and location\***

|  |  |
| --- | --- |
| Provider |       |
| CQC provider number: |       |
| Location name and address: |       |
| Location postcode: |       |
| CQC location number: |       |
| Regulated activity(ies) |       |
| This form filled in by: |       | Date submitted |       |
| Contact for more information (where different): |       |
| Telephone number: |       |
| Email address: |       |

**2. The person who died\***

|  |  |  |  |
| --- | --- | --- | --- |
| Unique identifier: | Date began to use service: | Their age range: | Please choose age range from:stillborn; <1; 1–4; 5–11; 12–15; 16–17; 18–24; 25–34; 35–44; 45–54; 55–64; 65–74; 75–84; 85+ |
|       |       |  |  |

**3. The circumstances of the death**

|  |  |  |
| --- | --- | --- |
| Cause of death (where known): | Date of death: | Time of death: |
|       |       |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Did the death take place during / within 30 days of surgery? | **Yes** | [ ]  | **No** | [ ]  | **N/k** | [ ]  |  |
| **If Yes:** what was the surgical procedure: |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Did the death take place during / within 30 days of the use of restraint? | **Yes** | [ ]  | **No** | [ ]  | **N/k** | [ ]  |  |
| **If Yes:** please provide more information in Part 7 on page 5 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Was the death the expected outcome of an illness or medical condition? | **Yes** | [ ]  | **No** | [ ]  | **N/k** | [ ]  |  |
| **IF Yes**: was the person receiving appropriate care and treatment? | **Yes** | [ ]  | **No** | [ ]  | **N/k** | [ ]  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Is the death subject to a formal investigation? | **Yes** | [ ]  | **No** | [ ]  | **N/k** | [ ]  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you notifying a death that occurred within 12 months of a termination of pregnancy (regulation 20)?**If yes,** please go straight to Part 7 on page 5 | **Yes** | [ ]  | **No** | [ ]  |  |
|  |

**If the death was expected and the person was receiving appropriate care and treatment, please go straight to Part 7 on page 5.**

**If the death was unexpected, please fill in Parts 4, 5, 6, 7 and 8 as needed.**

**4. Details of the last individual involved in providing care to the deceased**

|  |  |
| --- | --- |
| Unique identifier/code for the person: |       |
| Job title: |       |
| Was the person employed by the provider shown in part 1 above | **Yes** | [ ]  | **No** | [ ]  |  |
| **If No:** Name of employer |       |

**5. Medicines**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any concerns relating to the use of medicines? | **Yes** | [ ]  | **No** | [ ]  |  |

**If Yes: Details of the primary medicine of concern**

|  |  |
| --- | --- |
| Approved drug name: |       |
| Proprietary drug name drug name: |       |
| Manufacturer: |       |
| Batch: |       |
| Form: |       |
| Dose: |       |
| Strength: |       |
| Route of administration: |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do the concerns relate to a drug error? | **Yes** | [ ]  | **No** | [ ]  |  |
| **If Yes**: Type of drug error: |
| Drug overdose | [ ]  | Drug underdose | [ ]  | Drug not available | [ ]  |
| Missed dose | [ ]  | Wrong drug given | [ ]  |  |

|  |  |
| --- | --- |
| Other medicines in use at the time of death: |       |
|       |
|       |
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**6. Medical devices**

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| --- | --- | --- | --- | --- | --- |
| Are there any concerns relating to the use of medical devices? | **Yes** | [ ]  | **No** | [ ]  |  |

**If Yes: Details of the medical device**

|  |  |
| --- | --- |
| Type of device: |       |
| Product name: |       |
| Model number: |       |
| Catalogue number: |       |
| Serial number: |       |
| Batch number: |       |
| Date manufactured: |       |
| Where is the device now? |       |

**7. Circumstances of the death and any other relevant information not already described above \***

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|       |

Continue on additional numbered sheets if necessary. Box will expand if used on a computer.

**8. Additional information about the person**

**Funding (this item for non-NHS services only)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Self funded | [ ]  | PCT (whole or part) | [ ]  | Local authority (whole or part) | [ ]  |  |
| Name of PCT or LA |       |

**Gender**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Male | [ ]  | Female | [ ]  |  |
| Not specified | [ ]  |  |

**Ethnicity**

|  |
| --- |
| **White** |
| British | [ ]  | Irish | [ ]  |  |
| Other | [ ]  |  |
| **Mixed** |
| White / Black Caribbean | [ ]  | White / Black African | [ ]  |  |
| White / Asian | [ ]  | Other mixed background | [ ]  |  |
| **Asian** |
| Indian | [ ]  | Pakistani | [ ]  |  |
| Bangladeshi | [ ]  | Other Asian background | [ ]  |  |
| **Black or Black British** |
| Caribbean | [ ]  | African | [ ]  |  |
| Other | [ ]  |  |
| **Chinese** | [ ]  |  |
| **Other** |
| Other | [ ]  | Unknown | [ ]  |  |

**Disability**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physical | [ ]  | Learning | [ ]  |  |
| Sensory | [ ]  |  |

**Mental Health difficulties**

|  |  |  |
| --- | --- | --- |
| **Please tick/check here if the person has mental health difficulties** | [ ]  |  |

**Religion/Belief**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Baha’i | [ ]  | Buddhist | [ ]  |  |
| Christian | [ ]  | Hindu | [ ]  |  |
| Jain | [ ]  | Jewish | [ ]  |  |
| Muslim | [ ]  | None | [ ]  |  |
| Pagan | [ ]  | Sikh | [ ]  |  |
| Zoroastrian | [ ]  | Unknown | [ ]  |  |
| Other |       |

**Sexual identity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heterosexual / Straight | [ ]  | Gay or Lesbian | [ ]  |  |
| Bisexual | [ ]  | Other | [ ]  |  |
| Unknown | [ ]  |  |

**Please email your completed form to:** **HSCA\_notifications@cqc.org.uk**

**For CQC use only, please leave blank**

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