

**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: |  |
|  |
|  |

|  |
| --- |
| Statutory notification about the death of a person who used the service  Care 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**](mailto: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**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 \***

|  |
| --- |
|  |

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**](mailto:HSCA_notifications@cqc.org.uk)

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

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