THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1996)33

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG
26 March 1996

Dear Colleague

DEATHS IN HOSPITAL

Summary

1. This notice has been issued at the request of the Crown Office to remind Health Boards and Trusts of the circumstances under which a report of a death in hospital should be submitted to the Procurator Fiscal.

2. If a death falls within any of the categories listed in Annex A, it must be reported to the Procurator Fiscal who will carry out an Inquiry.

Action

3. Chief Executives and General Managers should ensure that all staff involved in the care of dying or deceased patients see this notice and are aware of its contents.

4. Chief Executives and General Managers should also ensure that local procedures for dealing with patients who die in hospital include reference to the list at Annex A.

Other Information

5. The Crown Office is concerned that not all deaths that should be reported are being reported and has asked if we would in particular draw your attention to those deaths which fall within category 21. Under this category any death where a complaint is received from the next of kin about the medical treatment given to the deceased and where there is any suggestion that the medical treatment may have contributed to the death of the patient, should be reported as soon as the complaint is received, if it has not already been reported under category 7. It is appreciated that such complaints may be unfounded, but Procurators Fiscal should be given the opportunity to investigate them.

Addressees

For action:
Chief Executives,
NHS Trusts

General Managers,
Health Boards

General Manager,
Common Services Agency

General Manager,
State Hospital Board for Scotland

For information:
Local Health Councils

General Manager,
Health Education Board for Scotland

Executive Director,
SCPMDE

Enquiries to:

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Provider Policy Development Division
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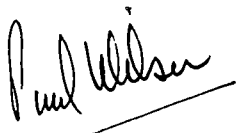
6. One Procurator Fiscal has recently discovered a number of deaths within his area which were not reported to him at the time but subsequently featured in press articles following complaints by relatives about medical care falling below an acceptable standard and leading to the patient's death. Failure by the hospitals to report the deaths timeously caused particular difficulties for the Procurator Fiscal.

7. On the implementation of the new NHS procedures from 1 April 1996 the Complaints Procedure Guidance given in NHS MEL(1995)13 dated 10 February 1995; NHS Circular GEN(1992)27 dated 7 October 1992 and NHS Circular No 1981(GEN)43 dated 30 November 1981 will be revoked. Directions and revised Guidance will issue in March which will cover the need to ensure such cases are reported for enquiry by the Procurator Fiscal.

8. This notice should be used in conjunction with NHS Circular GEN(1992)33 of 23 December 1992 entitled "PATIENTS WHO DIE IN HOSPITAL".

Yours sincerely



PAUL WILSON
Director of Trusts

ANNEX A

DEATHS TO BE REPORTED TO THE PROCURATOR FISCAL

Hospitals are asked to report to the Procurator Fiscal deaths occurring in the following categories to ensure that the Fiscal has the opportunity to conduct an Inquiry.

1. Any uncertified death.

2. Any death caused by an accident arising out of the use of a vehicle including an aircraft, a ship or a train.

3. Any death of a person while at work.

4. Any death resulting from an accident in the course of work or arising out of industrial disease or poisoning.

5. Any death due to poisoning.

6. Any death where the circumstances indicate that suicide may be a possibility.

7. Any death where there are indications that it occurred as a result of medical mishap, ie:

    a. deaths which occur unexpectedly having regard to the clinical condition of the deceased prior to his receiving medical care;

    b. deaths which are clinically unexplained;

    c. deaths seemingly attributable to therapeutic or diagnostic hazard;

    d. deaths which are apparently associated with lack of medical care;

    e. deaths which occur during the actual administration of general or local anaesthetic; and

    f. deaths which may be due to an anaesthetic.

8. Any death resulting from an accident.

9. Any death following an abortion or attempted abortion.

10. Any death where the circumstances seem to indicate fault or neglect on the part of another person.

11. Any death occurring while the deceased was in legal custody as defined in section 1(4) of the 1976 Act.

12. Any death of a new born child whose body is found.

13. Any death (occurring not in a house) where a deceased's residence is unknown.

14. Any death by drowning.

15. Any death of a child from suffocation including overlaying.

16. Any death which may be sudden death in infancy syndrome.

17. Any death occurring as a result of food poisoning or an infectious disease.

18. Any death by burning or scalding or as a result of a fire or explosion.

19. Any death of a foster child.

20. Any other death due to violent, suspicious or unexplained cause.

21. Any death where a complaint is received from the next of kin about the medical treatment given to the deceased, and where there is any suggestion that the medical treatment may have contributed to the death of the patient.