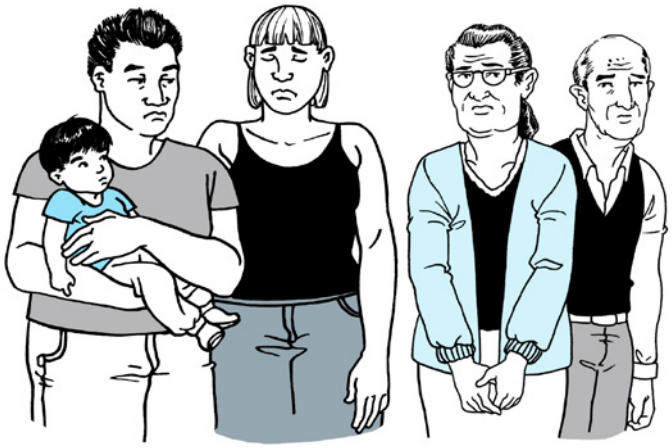
Easy Read

NHS England

Information after someone dies in NHS care

This leaflet is about what happens when someone dies in NHS care.



It is for the person's family and others who were close to them.

Understanding what happened

The staff who cared for your loved one can answer questions about what happened to them.

You can also tell them about any concerns or comments you have about what happened.

You might not feel ready to talk about this now.

You can also speak to our PALS - the Patient and Advice Liaison Service - if you want to:

Trust to insert local details

Contacting us

After someone dies in NHS care we write to a family member or to the person who represented them.

The letter says who you can contact to give comments or raise concerns about the care your loved one was given.

If you need to speak to someone before this letter comes you can contact us:

Trust to insert local details

Help with things you might need to do after someone dies

We can give you information and advice about the things you might need to do after the death of your loved one.

You might need to collect their belongings or get help to register your loved one's death.

We can also help you find support for how you feel.

To get this help contact us:

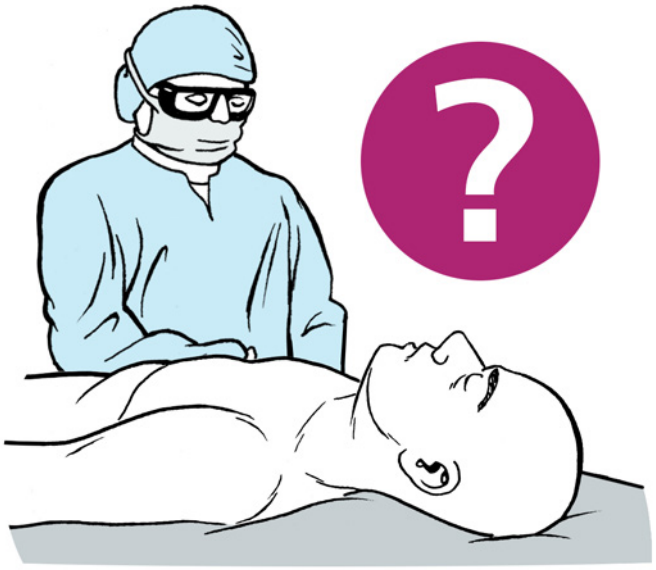
Trust to insert local details

What happens when a death in NHS care is looked into further

When someone dies in NHS care we might look into it further.

This is to find out if the care they were given was good or could have been improved.

This leaflet tells you about the ways this is done.



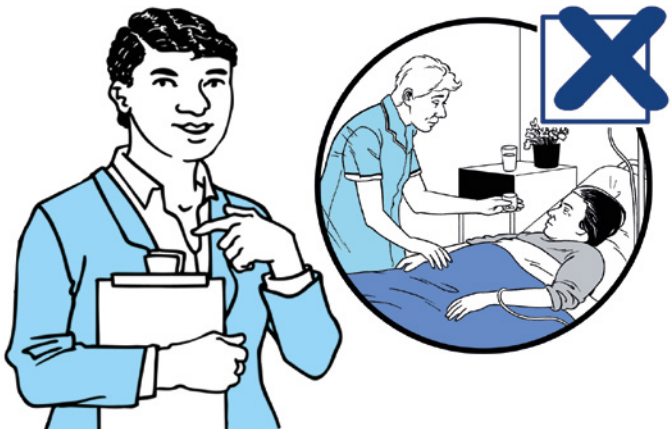
This leaflet tells you about things that might happen to look into the care your loved one was given these include:

- Reviews of deaths in NHS care (page 7)
- Investigations to look into things further (page 9)
- When a coroner looks into a death (page 10)
- Complaints and feedback (page 13)

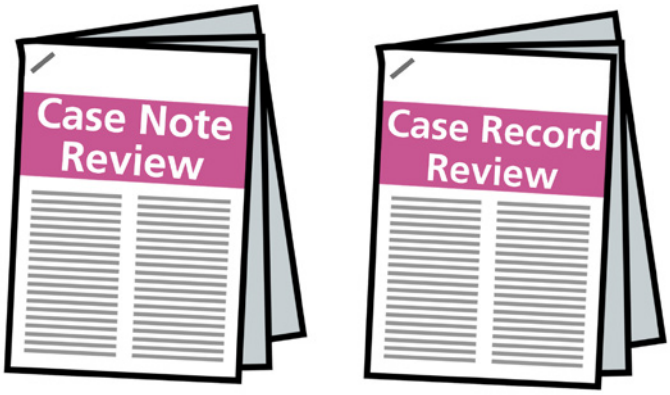
At the end of this leaflet there is information about other organisations that can support you to ask questions, raise concerns or make a complaint.

Reviews of deaths in NHS care

When someone dies in NHS care we might do a review.



A review is where someone who was not part of your loved one's care looks into what happened.



A review is sometimes called a case note review or a case record review.

Case notes and case records are the health records about the care your loved one was given.

The person who does the review looks into all the care your loved one got to see how well it was given.

Reviews are to find out if anything went wrong or could have been done better. If you raise serious concerns about your loved one's care we will do a review.

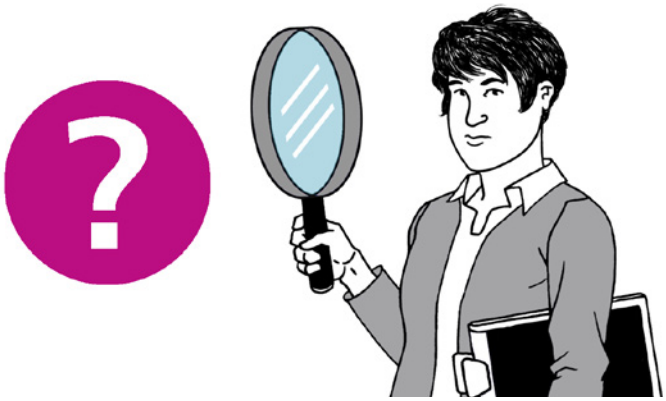
And reviews help us learn from what happened and do things better in the future.

When some people die in our care we will do a different type of review. If we do a different type of review we will tell you this.

For example, we will do this is your loved one had a learning disability.

Investigations

If we think that the care or treatment we gave your loved one was part of the reason they died, we will do an investigation.

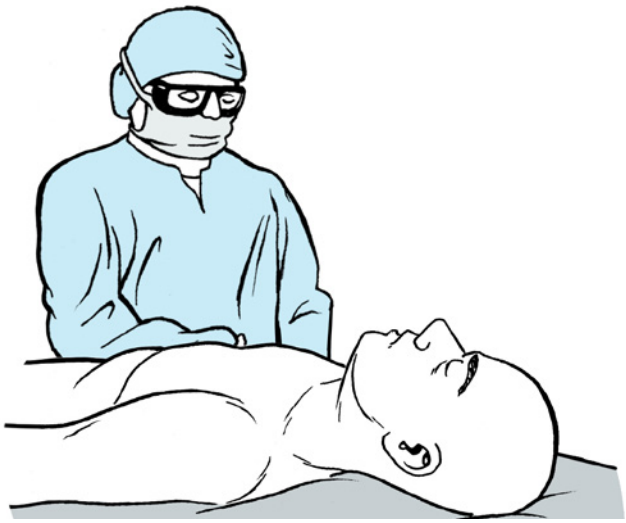


An investigation is where someone looks further into what happenedand why.

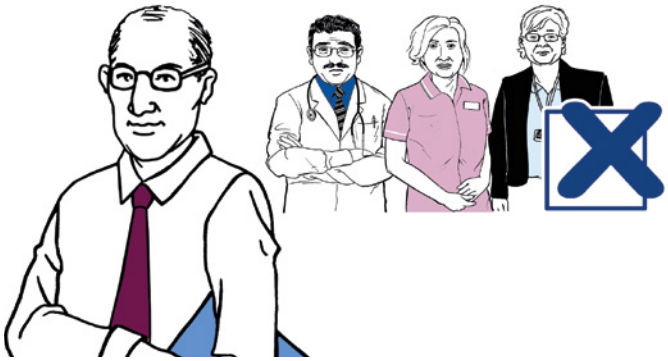
If we do an investigation we will let you know how you can be involved and have your say.

An investigation will help us learn from what happened to your loved one so we can improve in the future.

When a coroner looks into a death

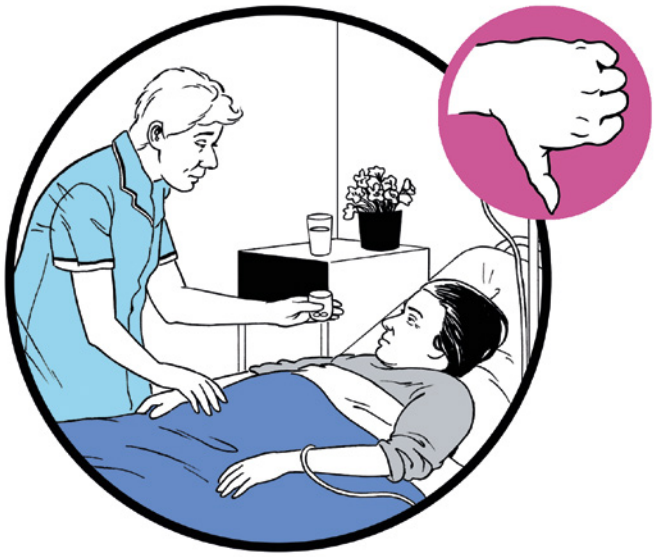


Some deaths are reported to a coroner.



A coroner is an independent person who looks into what happened when someone dies and the reason for their death is unknown, violent or unnatural.

Coroners are involved when it is not known why a person died.



And coroners are involved when there might have been something that went wrong with the care of someone who died.

We will tell you if we have asked a coroner to look into what happened to your loved one.

If you have concerns about the NHS care your loved one got you can ask the coroner to look into it.

You should contact the coroner as soon as possible.

To get the details of the local coroner ask us:

Trust to insert local details

Coroners' inquests

The coroner may decide there needs to be an inquest.

An inquest is a public investigation to find out more about how your loved one died.

The coroner can give you more information about what will happen in the inquest.

You can get support to have your say in an inquest.

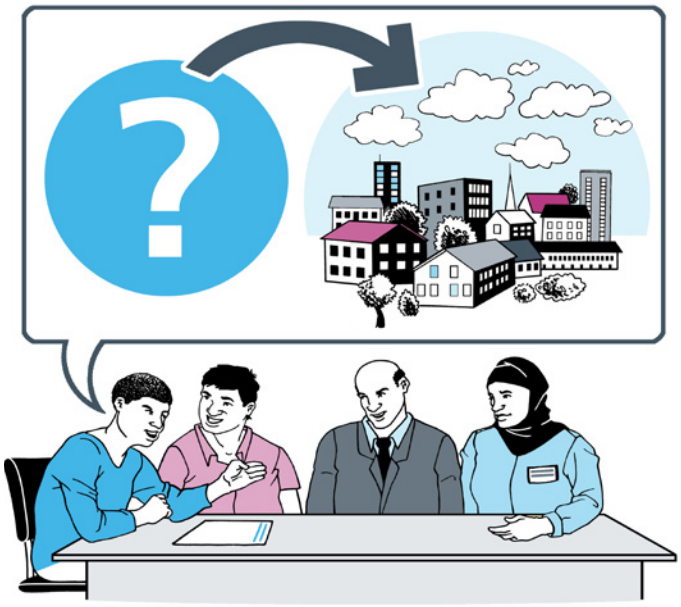
There is a list of organisations at the end of this leaflet who can support you or who can help you get support.

Complaints and feedback

At the end of this leaflet there is a list of organisations who can also help you have your say.

You can make a complaint to us about the care we gave your loved one if you feel it was not good enough.

Or you can make a complaint to the local clinical commissioning group or NHS England.



Clinical commissioning groups and NHS England are the parts of the NHS that buy health services.

You should try to make your complaint within a year of you realising you have something to complain about.

We will answer you complaint in an accessible format. Followed by an answer in writing if you need one.

If you are not happy with our answer you can challenge it with an organisation called the Parliamentary and Health Service Ombudsman.

You can ring the Parliamentary and Health Service Ombudsman on **0345 954 033**.

Support and advice you can get

We will give you information you need about any comments, concerns or complaints you have.

You can also get independent support and advice from organisations that are not part of the NHS.

These organisations can help you understand the different ways we look into what happened to your loved one.

They can help you understand the medical and legal words you might come across.

They can help you have your say about what happened to your loved one.

They can help you find other organisations that can also help.

Organisations

These organisations can help you understand more about what is happening and what your rights are.

RESPOND
from hurting to healing

avma
action *against* medical accidents

Action against Medical Accidents ('AvMA'): An independent national charity that offer free advice on:

- NHS investigations
- Complaints to the NHS
- Taking legal action about medical accidents

Most advice is given by telephone or in writing but advocacy may also be arranged. They can also help you get other advice and support.
www.avma.org.uk – **0845 123 23 45** (Mon-Fri, 10am-3.30pm).

Advocacy after Fatal Domestic Abuse: Help for families when reviews and investigations are being done after someone dies because of domestic abuse.

https://aafda.org.uk/ - **07768 386 922**

Child Bereavement UK:

- Supports families when a baby or child of any age dies or is dying.
- Support for a child or young person up to age 25 when somebody dies.
- Support for adults to help a child or young person when somebody dies.
- Support includes face to face sessions and booked telephone support.

www.childbereavementuk.org – **0800 028 8840**

Child Death Helpline: Provides a free phone helpline for anyone affected by a child's death, from before birth to the death of an adult child.
This support is offered no matter how long ago the child died.

www.childdeathhelpline.org.uk – 0800 282 986/0808 800 6017

Cruse Bereavement Care: Support for adults and children when someone dies, by telephone, email or face-to-face.

www.cruse.org.uk - **0808 808 1677**

hundredfamilies.org

Hundred Families: Offers support, information and practical advice for families bereaved by people with mental health problems, including information on Health Service Investigations.
www.hundredfamilies.org

INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST: Support for families when someone has died while held by the police or in prison or in a mental health setting. Free independent advice on investigations, inquests and other legal processes.
www.inquest.org.uk – **020 726 3111** option 1

nsun National Survivor User Network

National Survivor User Network: A network of mental health service users and survivors who campaign for improvements. It also has a useful page of links to user groups and organisations that offer counselling and support.
www.nsun.org.uk

the patients association

Patients Association: Provides support and guidance to family members. Their national helpline gives specialist information and advice. This does not include medical or legal advice. It can also help you make a complaint to the CQC (Care Quality Commission).
www.patients-association.org.uk - **020 8423 8999**

Sands: Supports those affected by the death of a baby before, during and shortly after birth. They provide a telephone helpline, a network of support groups, and an online forum.
www.sands.org.uk – **0808 164 3332**

Support after Suicide Partnership: Provides helpful resources for those bereaved by suicide. They can give details of local support groups and organisations.
www.supportaftersuicide.org.uk/

local organisations

Trusts to add details of any local organisations, especially those that have specialism working with people with a learning disability

Other organisations that may be of help

Clinical commissioning groups (CCGs):Clinical commissioning groups pay for and monitor NHS services. Complaints can be made to the CCG instead of us if you prefer. Please ask us for contact details of the CCGs that monitor our services.
Or you can find your local CCG at www.england.nhs.uk/ccg-details

Care Quality Commission (CQC): The CQC is the independent monitor for health and adult social care in England. The CQC is interested in knowing about the quality of health and care services. They do not investigate individual complaints. Feedback can be reported on the 'My Experience' page of their website.
Visit: www.cqc.org.uk.

National Reporting and Learning System (NRLS): Members of the public can report patient safety incidents to the NRLS. This is run by a part of the NHS called NHS Improvement. Reports help show where there are patient safety issues that need to be looked into. The NRLS does not look into individual reports. They do not reply to individual reports.
www.improvement.nhs.uk/resources/report-patient-safety-incident/

NHS England

NHS England – Specialised Services: Specialised services support people with a range of rare conditions. Services for rare conditions are planned nationally rather than in each local area. If you wish to raise a concern a specialised service contact NHS England's contact centre.
Email: england.contactus@nhs.net or telephone **0300 311 22 33**

Nursing & Midwifery Council

Nursing and Midwifery Council (NMC): The NMC sets standards for nurses and midwives. They have a Public Support Service that puts patients, families and the public at the centre of their work. More information can be found in the 'Concerns about nurses or midwives' section on their website.
www.nmc.org.uk

General Medical Council

General Medical Council (GMC): The GMC has the official register of qualified medical staff in the United Kingdom. They protect the health and safety of the public. They can suspend people or take them off the register when necessary. Their guides for patients and the public can help you decide which organisation is best to help you. More information can be found in the 'Concerns' section on their website.
www.gmc-uk.org

Healthcare Safety Investigations Branch (HSIB): HSIB's improve safety through investigations. Their investigations do not blame anyone and are for learning about patient safety. Anyone can share cases with HSIB.
They do not investigate all cases.
www.hsib.org.uk

This easy read document has been produced by CHANGE
www.changepeople.org