

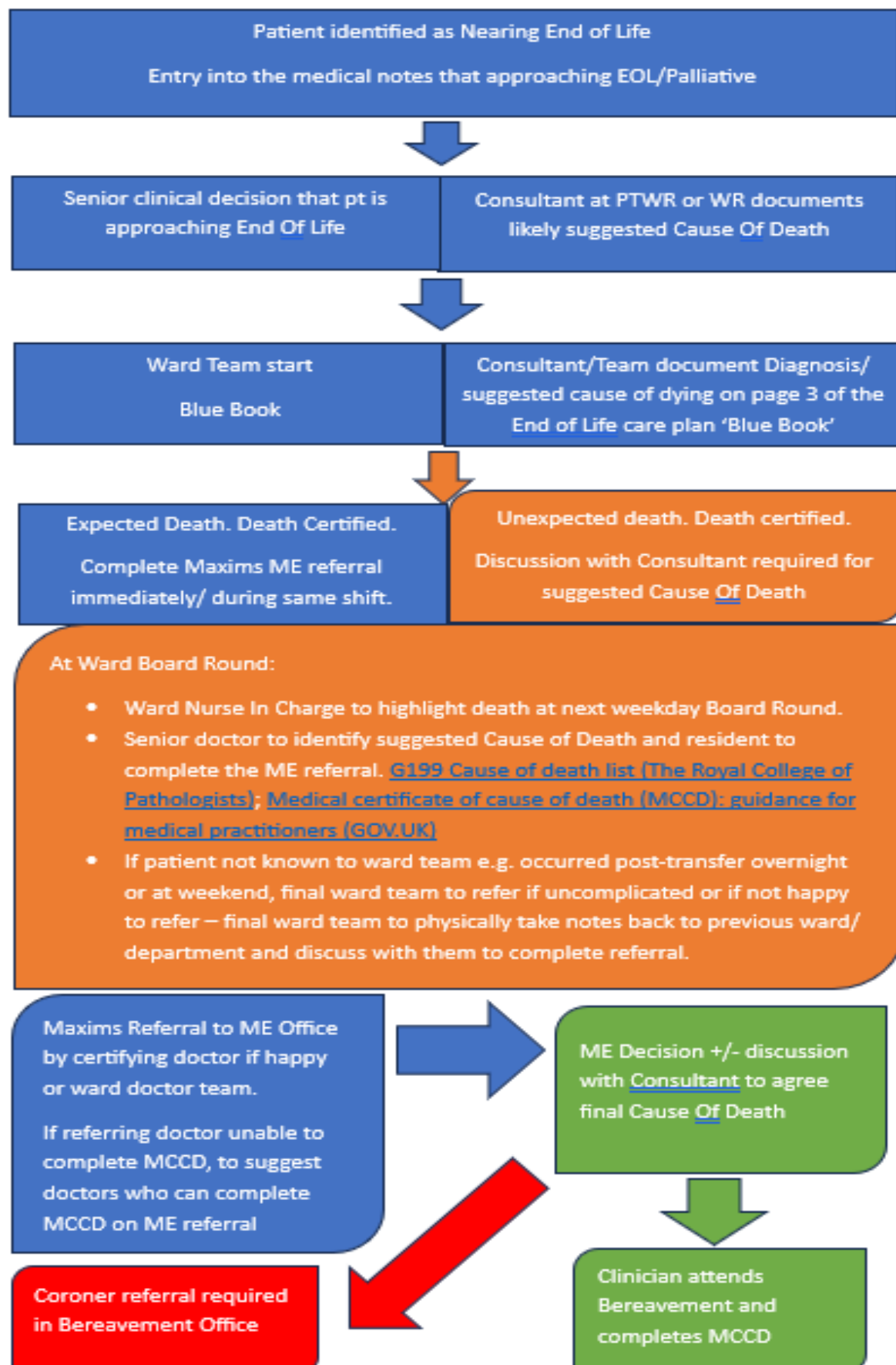
Bereavement Clinical Guideline

V1.0

August 2026

Summary

BEREAVEMENT PROCESS FLOWCHART



1. Aim/Purpose of this Guideline

The aim of this guideline is to support hospital teams in navigating the bereavement process in a structured, compassionate, and timely manner. It ensures that patients and their families remain the central focus throughout, and that all required documentation, communication, and referrals are appropriately completed before, during, and after death.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Care Before Death

- 2.1.1. The '[Caring for Patients at the End of Life](#)' (Blue Book) Care Plan CHA3739V4 is suitable for all patients who are expected to die imminently and must be used in accordance with RCHT policy.
- 2.1.2. The decision to commence the Blue Book Care Plan should be led by a senior doctor following discussion with the wider multidisciplinary team (MDT).
- 2.1.3. Any member of the MDT may raise the possibility that a patient is approaching the end of life.
- 2.1.4. In the absence of a senior doctor, delays in commencing end-of-life care must be avoided. Advice should be sought from the most senior doctor available.
- 2.1.5. The consultant responsible for the patient's care at the time the End-of-Life Care Plan is initiated must document the expected cause of death within the Care Plan to facilitate Medical Examiner scrutiny.
- 2.1.6. Appropriate guidance should be used when determining cause of death [G199 Cause of death list \(The Royal College of Pathologists\)](#).

- 2.1.7. Where possible, senior doctors should identify whether referral to the Coroner is likely to be required and whether a post-mortem examination may need to be considered. Discussions with the Medical Examiner's Office can support decision-making regarding cause of death and whether a referral is indicated or required.

2.2. Care After Death

- 2.2.1. There is a [Care After Death Policy](#) on the RCHT Clinical Shelf. Salient points for medics in the bereavement process are highlighted below.
- 2.2.2. Verification of death may be undertaken by either a doctor or a nurse who has been assessed as competent to perform this role.
- 2.2.3. The patient's notes should remain on the ward to enable the medical team and responsible consultant to determine and document an appropriate cause of death. G199 Cause of death list (The Royal College of Pathologists)
- 2.2.4. A doctor must complete a referral to the Medical Examiner via Maxims as soon as reasonably practicable following death verification. The ward doctor or the on-call doctor completing the Death Verification can complete and submit the referral to the office if known to them and a suggested cause of death is documented in the patient notes/ Blue Book by the responsible medical team.
- 2.2.5. Wherever possible, the doctor completing the Medical Examiner referral should also be able to complete the Medical Certificate of Cause of Death (MCCD). Medical certificate of cause of death (MCCD): guidance for medical practitioners (GOV.UK)
- 2.2.6. If a doctor does not know the patient, the Medical Examiner referral should contain suggested doctors who knew the patient in order to complete the MCCD.
- 2.2.7. Medical Examiner referral:
 - 2.2.7.1. If the doctor knows the patient and is confident in completing the Medical Examiner referral, this should be completed immediately following death verification, whether in-hours or out of hours.
 - 2.2.7.2. If the doctor verifying the death did not know the patient, or no suggested cause of death has been documented, the case should be discussed at the next consultant ward round to ensure the Medical Examiner referral is completed.
 - 2.2.7.3. If the patient is unknown to the current team, and/or the consultant is unable to suggest a cause of death, responsibility for review and referral to the Medical Examiner should be transferred to the most appropriate previous clinical team without delay.
 - 2.2.7.4. Responsibility for ensuring that an acceptable cause of death is documented and that a timely Medical Examiner referral is completed rests with the consultant responsible for the patient's care at the time of death.

- 2.2.8. Doctors contacted by the Medical Examiner's Office to complete an MCCD should do so as soon as reasonably practicable. If this is not possible, the Medical Examiner's Office should be informed promptly, together with the reason for the delay (for example annual leave, sickness absence or prolonged absence from the Trust).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Adherence to the process by all ward teams for all inpatient deaths.
Lead	Dr J Baden-Fuller, Deputy Chief Medical Officer.
Tool	Escalation emails relating to delays in the bereavement process. Datix and Complaints around delays.
Frequency	Quarterly review of escalations, complaints and Datix reports relating to bereavement processes.
Reporting arrangements	Findings will be reported to the Mortality Review Oversight Group (MROG) and escalated through Divisional Governance structures where required.
Acting on recommendations and Lead(s)	The Deputy Chief Medical Officer and Medical Examiner Lead will oversee the implementation of actions arising from identified deficiencies. Progress will be monitored through the relevant governance groups.
Change in practice and lessons to be shared	Lessons learned will be disseminated through governance meetings, medical staff communications, and educational forums. Any changes required to practice will be implemented within agreed timescales and monitored for effectiveness.

4. Equality and Diversity

- 4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

- 4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Bereavement Clinical Guideline V1.0
This document replaces (exact title of previous version):	New
Date Issued/Approved:	August 2026
Date Valid From:	August 2026
Date Valid To:	August 2029
Directorate/Department responsible (author/owner):	Laura Wesson, Consultant Geriatrician. Jo Baden-Fuller, Deputy Chief Medical Officer. Jonathan White, Medical Examiner Lead.
Contact details:	laurawesson@nhs.net j.badenfuller@nhs.net jonathan.white9@nhs.net
Brief summary of contents:	Guidance on Bereavement process documentation, Medical Examiner referrals, and completion of the Medical Certificate of Cause of Death (MCCD).
Suggested Keywords:	Medical examiner referral, cause of death, end of life.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Mortality Review Oversight Group Meeting
Manager confirming approval processes:	Jillian Tozer, Associate Director of Quality Governance
Name of Governance Lead confirming consultation and ratification:	Becky Cooper, Clinical Effectiveness Manager
Links to key external standards:	Death certification reform and the introduction of medical examiners - GOV.UK

Information Category	Detailed Information
Related Documents:	G199 Cause of death list (The Royal College of Pathologists) Care After Death Policy Medical certificate of cause of death (MCCD): guidance for medical practitioners (GOV.UK)
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / End of Life

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
May 2026	V1.0	New	Laura Wesson, Consultant Geriatrician.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#)

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net