**Notification of death form
(ND1)**

This form is to be used to notify the Mental Welfare Commission of **all** patient deaths in the following categories within one week of awareness. Please send completed forms to mwc.enquiries@nhs.scot

|  |  |
| --- | --- |
|  | Please cross |
| 1. The deceased was subject to compulsory treatment under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or Criminal Procedure (Scotland) Act 1995 at the time of death

**ALL DEATHS IN THIS CATEGORY MUST ALSO BE REPORTED TO THE PROCURATOR FISCAL** **(Form EF5 – please attach if available)** |  |
| 1. The deceased died within one month of cease of detention under the above Acts
 |  |
| 1. The patient died as a result of actual or suspected suicide as an inpatient or within one month of discharge from hospital based care.
 |  |
| 1. There is a significant concern regarding an aspect of the care and treatment prior to the patient’s death.
 |  |

**Part 1. Particulars of the deceased and nearest relative**

|  |  |
| --- | --- |
| CHI Number |  |
| Surname |  |
| First name(s) |  |
| Other / Known as |  |
| Date of birth (dd/mm/yyyy) |  |
| Home address |  |
| Postcode: |  |
| Gender (cross) | Male |  | Female |  |
| General Practitioner(name, address and telephone number) |  |
| Name of nearest relative |  |
| Relationship to the deceased |  |
| Address of nearest relative |  |
| Phone number |  |

**Part 2. Details of reporter / RMO**

|  |  |
| --- | --- |
| Reporter full name |  |
| Title |  |
| Contact address |  |
| Contact phone number |  |
| Reporter’s email address |  |
| Name of consultant / RMO (if this is not the reporter) |  |
| Consultant contact phone number |  |
| Consultant email address |   |

**Part 3. Details of detention (any detention within one month of death if applicable)**

|  |
| --- |
| The deceased was subject to detention under the following order (or died within one month) |
| Name of order |  |
| Start date of order |  |
| End date of order (if applicable) |  |
| Under the management of (Name of hospital or HSCP etc) |  |
| Name of Mental Health Officer (MHO) |  |
| MHO address |  |
| MHO email address |  |
| MHO phone number |  |

**Part 4. Circumstances of death**

|  |  |
| --- | --- |
| Date and time of death |  |
| Place of death (incl address) |  |
| Has a death certificate been issued | Yes / No |
| Cause of death if certificate issued |  |
| Name of certifying doctor |  |
| If certificate has not been issued please provide the presumed cause of death in general terms if known  |  |
| Has a post mortem been planned or carried out? | Yes / No |
| Is the death the result of an actual suicide? | Yes / No |
| Is the death the result of a possible or suspected suicide (not confirmed)? | Yes / No |
| Is the death caused by coronavirus infection? | Confirmed / Suspected / No |

**Part 5. Clinical details / history**

|  |  |
| --- | --- |
| Relevant past medical history |  |
| Relevant past psychiatric history |  |
| Alcohol and illicit drug use history |  |
| Prescribed medication at time of death (note also if ‘high-dose’ ie above total BNF combined dose limits) |  |
| Summary of main events prior to death (please attach copies of any relevant information including discharge summary etc) |  |
| Was the patient on authorised pass, leave or suspension of detention at the time of death (hospital CTO)? | Yes / No |
| Was the patient on unauthorised absence at the time of death (hospital CTO)? | Yes / No |
| Have the circumstances of the death been discussed verbally with the nearest relative (face to face/telephone)? | Yes / No | Date of discussion if held: |
| Has the **nearest relative** expressed any concerns about the circumstances surrounding the death – either verbally or in writing (if yes please specify)? |  |
| Have **you** any concerns about the circumstances surrounding the death (if yes please specify)? |  |

**Part 6. Reporting and investigation**

|  |  |  |
| --- | --- | --- |
| Has the death been reported to the procurator fiscal? | Yes / No  | Date: |
| Is the death subject to internal NHS review through adverse event investigatory procedures (including standard reporting eg Datix)? | Yes / No |
| Reference number (eg Datix or other) |  |
| Contact name of senior service manager (if known) |  |
| Address of hospital or Health and Social Care Partnership |  |
| If no, please provide reason  |  |

**Part 7. Declaration**

I confirm that the details contained in this form are accurate to the best of my knowledge.

|  |  |
| --- | --- |
| Signature (e-signature): |  |
| Date: |  |