Justice Health and
Forensic Mental Health Network

Justice Health NSW Policy

Management of a Death

Issue Date: 04 December 2025

Together for
Healthier Tomorrows

Management of a Death

Policy Number 1.120

Policy Function Continuum of Care

Issue Date 04 December 2025

Next Review Date 04 December 2029

Risk Rating Medium

Summary This policy provides health staff with clear guidelines for the management, recording and documentation of deaths in custody covered by Justice Health and Forensic Mental Health Network (Justice Health NSW) and privately managed centres within NSW.

Responsible Officer Director Clinical Governance

Applies to
☒ Administration Centres
☐ Community Sites and programs
☒ Health Centres - Adult Correctional Centres or Police Cells
☒ Health Centres - Youth Justice Centres
☒ Long Bay Hospital
☒ Forensic Hospital

CM Reference POLJH/1120

Change summary Included voluntary assisted dying, updated to include alignment to restructure.

Authorised by Chair, Policy Steering Committee

Revision History

#	Issue Date	Number and Name	Change Summary
5	Dec 25	1.120 Management of Death	Included voluntary assisted dying, updated to include alignment to restructure.
4	July 24	1.120 Management of Death	Incorporated FH local Procedure into this Policy (section 3.2 Forensic Hospital, pages 6-8 added). Made references to PD2010_054 Coroners Cases and the Coroners Act 2009 to differentiate between a death in custody and a death in a mental health facility as defined by the PD. Update who is responsible for contacting Designated carer/Principal care provider/NoK. Position and title changes throughout. Inclusion of “death in care” should a death happen in the Forensic Hospital

3	Jan 23	1.120 Management of Death	MoH PD2021_029 Death Verification of Death and Medical Certificate of Cause of Death, no longer applies to Justice Health NSW MoH Life Extinct Form no longer applies therefore there is a need to adapt form to become a Justice health NSW Form (completed)
2	Jan 18	1.120 Management of Death	MoH PD2015_40 Death Verification of Death and Medical Certificate of Cause of Death, no longer applies to JH&FMHN MoH Life Extinct form no longer applies therefore there is a need to adapt form to become a JH&FMHN form (completed) Inclusion of the Forensic Hospital
1	Jul 13	1.120 Management of Death	Name of policy changed to manage the death of clients within the custodial environment, the Long Bay and Forensic Hospitals and the community whilst under the care of JH&FMHN. Guideline changes to facilitate compliance with NSW Ministry of Health policy PD2012_036 Death - Extinction of Life and the Certification of Death allowing for either a Medical Officer or a Registered Nurse to declare life extinct. Inclusion of High-Level Open Disclosure process in compliance with NSW Ministry of Health PD 2007_040 Open Disclosure

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Always refer to the electronic copy for the latest version.

Justice Health and Forensic Mental Health Network

PO BOX 150 Matraville NSW 2036

Tel (02) 9700 3000

http://www.justicehealth.nsw.gov.au

Table of Contents

1. Preface 5
2. Policy Content 5
2.1 Mandatory Requirements 5
2.2 Correctional and Youth Justice Centres including Long Bay Hospital roles and responsibilities 6
2.3 Forensic Hospital roles and responsibilities 7
2.4 Clinical Governance Unit Responsibilities 8
Patient Safety Team 8
2.5 Health Information and Records Services (HIRS) Responsibilities 8
2.6 Assessment and Certification of Life Extinct 8
2.7 Certification of Death 9
2.8 Scene of death 9
2.9 Notification 9
2.10 Documentation 10
2.11 Health Record 11
2.12 The Commissioner's Report 11
2.13 Debriefing 11
2.14 Investigation 12
2.15 Coronial Inquiry 12
2.16 Open Disclosure 12
2.17 Media Interest 12
2.18 More Information and Assistance 12
3. Definitions 12
4. Related Documents 13

1. Preface

All deaths in NSW Correctional Centres, Youth Justice Centres, Long Bay and Forensic Hospitals are subject to internal review and an investigation by the Coroner. Justice Health and Forensic Mental Health Network (Justice Health NSW) has developed this policy for the management, reporting and documentation of the death of a patient.

2. Policy Content

2.1 Mandatory Requirements

- Under the Section 6 of the Coroners Act 2009 the following incidents are reportable and will be managed in accordance with PD2024_036 Coroners Cases and the Coroners Act 2009:

  (i) All deaths in custody.
  (ii) Death of a patient who is in, or temporarily absent from, a declared mental health facility within the meaning of the Mental Health Act 2007 (NSW) and while the person was a patient at the facility for the purpose of receiving care, treatment or assistance under the Mental Health Act 2007 (NSW) or Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW).
- All deaths are also managed in accordance with the requirements of PD2020_047 NSW Health Incident Management and the Health Administration Act 1982, to effectively respond to clinical incidents and act on lessons learned.
- All deaths must be immediately notified to Justice Health NSW senior management via the executive group paging service.
- All deaths must be notified in the Incident Management System (ims+) as either a Harm Score 1 for unexpected deaths or as a Harm Score 4 for expected deaths. Harm Score 1 deaths will be reviewed utilising approved NSW Health Serious Adverse Event Review (SAER) methodology. Harm Score 4 deaths may be reviewed utilising either SAER methodology or an approved death screen tool.
- Harm Score 1 deaths in NSW Correctional and Youth Justice Centres, Long Bay and Forensic Hospitals are reported to NSW Ministry of Health (MoH) via a Reportable Incident Brief (RIB).
- Harm Score 4 deaths in NSW Correctional and Youth Justice Centres, Long Bay and Forensic Hospitals are only reported to NSW Ministry of Health (MoH) via a Reportable Incident Brief (RIB) if a SAER is used as the review methodology.
- All deaths in NSW Correctional and Youth Justice Centres, Long Bay and Forensic Hospitals are investigated by the Coroner including Voluntary Assisted Dying Deaths as per PD2024_036 NSW Health Coroners Cases and Coroners Act 2009.
- The Coroner will issue a death certificate following examination of the deceased. Death certificates cannot be issued by a Justice Health NSW Medical Officers or any other person.
- Corrective Service NSW (CSNSW) or Youth Justice NSW (YJNSW) are responsible for reporting a death immediately to the Police. The Police are responsible for notifying the patient's next of kin (NOK) and emergency contact person (ECP).

- In the Forensic Hospital the Service Director Forensic Hospital (SDFH) or delegate or the Forensic Hospital After Hours Nurse Manager (FH-AHNM) are responsible for reporting a death immediately to the Police.
- Justice Health NSW policy allows for a registered nurse (RN) or medical officer to assess a patient for extinction of life. Justice Health NSW JUS010.515 *Life Extinct Form* must be completed by a RN or MO. The original form must accompany the original health record, and a copy must accompany each copied health record.

Clinical findings must be documented by nursing staff and medical officer (MO) if in attendance at the site, and the fact that the patient is deceased must be recorded in the patient's health record. There is no requirement to call the MO into the centre if there is not one on duty onsite.

2.2 Correctional and Youth Justice Centres including Long Bay Hospital roles and responsibilities

Director of Nursing Clinical Support, responsibility:

- During business hours, the Director of Nursing Clinical Support must notify Justice Health NSW General Manager Primary Care who will brief the Chief Executive of events.
- The Director of Nursing Clinical Support must advise Justice Health NSW senior management of the death of a patient using the Executive Group Page system.

After Hours Nurse Manager's (AHNM) (state-wide) responsibility:

- The AHNM must notify the Justice Health NSW Executive on Call who will brief the Chief Executive.
- The AHNM must advise Justice Health NSW senior management of the death of a patient using the Executive Group Page system.

Medical Officer's responsibility:

- To respond and assist with any clinical resuscitation if on site.
- Verify 'life extinct' in the patient's health record, and complete JUS010.515 *Life Extinct Form*, if on site and requested.
- Record all clinical findings and that the patient has died in the patient's health record if on site.

Nurse's responsibility:

- To respond and perform any clinical resuscitation as required.
- During business hours notify the Director of Nursing Clinical Support immediately. If the Director of Nursing Clinical Support is not available, call the AHNM phone on [redacted]
- The AHNM must be notified immediately on [redacted] if the death occurs after hours.
- The death of a patient must be recorded as a clinical incident in ims+. The incident number is to be recorded in the patient's health record as soon as possible following the death.
- When a death occurs at an external hospital it is the responsibility of the Health Centre attending the Daily Hospital Update Form to notify the death in ims+.
- Justice Health NSW staff in attendance must document the events surrounding the death in the patient's health record.

- Verify 'life extinct' through required clinical assessment. Document this assessment on the JUS010.515 *Life Extinct Form* and also document verification in the patient's health record.
- Clinical notation in the patient's health record in relation to the death must be completed prior to ceasing duty.
- If there are any paper health records on site of the deceased, the paper health record must be sent to Health Information and Records Service (HIRS) after the patient's death. HIRS operating hours are Monday to Friday business hours.
- Justice Health NSW staff in attendance must contact the Justice Health NSW Legal Advisor for assistance in completing a draft statement for the Coroner. This must occur within 7 days of the incident.

2.3 Forensic Hospital roles and responsibilities

The DDON, SDFH and FH-AHNM responsibility:

- The DDON (or FH-AHNM outside of business hours) will notify the SDFH who will then advise the General Manager Forensic Mental Health (GMFMH) who will brief the Chief Executive (CE) of events.
- The SDFH (or FH-AHNM outside of business hours) must advise Justice Health NSW senior management group of the death of a patient using the Executive Group Page.

The DDON and FH-AHNM responsibility:

- The DDON (or FH-AHNM outside of business hours) acting as Local Incident Controller (LIC) will determine the appropriate emergency level as per Policy 5.017 *Management of Emergencies – Forensic Hospital Level 4* (containment) should be used for all expected deaths and level 5 (lockdown) should be used for all unexpected deaths.
- During business hours the LIC (DDON or FH-AHNM outside of business hours) will contact NSW Police who will attend the death and act on behalf of the Coroner.

Medical Officer's responsibility:

- To respond and assist with any clinical resuscitation if on site.
- Verify 'life extinct' in the patient's health record, and complete JUS010.515 *Life Extinct Form*, if on site and requested.
- Record all clinical findings and that the patient has died in the patient's health record if on site.

Designated carer/Principal care provider/NoK notification:

- **Civil and Forensic Patients**: the treating Psychiatrist or Registrar on duty is to inform the Designated carer/Principal care provider of the patients death. This initial notification may also satisfy the PRA requirement of an appointed Clinician Disclosure, or the PRA may allocate a clinician for further follow up with the Designated carer/Principal care provider in accordance with PD2023_034 *Open Disclosure*. The Tribunal must also be notified of the death via [redacted] who will then determine if any registered victims need to be notified via the Specialist Victims Support Service (SVSS).
- **Correctional patients**: the treating Psychiatrist or Registrar on duty is to inform CSNSW via [redacted] of the patients death who will then determine if any registered victims need to be notified via the appropriate body. Typically, when a correctional patient dies CSNSW will advise NSW Police who then contact the NoK.

- For those patients who are not Australian permanent residents or citizens, a notification of death must be made to the relevant Embassy.

Nurse's responsibility:

- To respond and perform any clinical resuscitation as required.
- During business hours notify the Nursing Unit Manager (NUM) immediately who will then notify the DDON (or FH-AHNM outside of business hours).
- Section off the area if possible close off the area and direct all patients to return to their bedroom and remain there. Follow guidance in section 3.2 on managing the scene.
- Ensure no one enters the scene until NSW Police are in attendance. When NSW Police arrive follow all reasonable instruction and assist where reasonable and appropriate.
- The death of a patient must be recorded as a clinical incident in ims+. The ims+ number must be recorded in the patient's health record as soon as possible following the death.
- Justice Health NSW staff in attendance must document the events surrounding the death in the patient's health record.
- Verify 'life extinct' through required clinical assessment. Document this assessment on the JUS010.515 *Life Extinct Form* and also document verification in the patient's health record.
- Clinical notation in the patient's health record in relation to the death must be completed prior to ceasing duty.
- If there are any paper health records on site of the deceased, the paper health record must be sent to Health Information and Records Service (HIRS) after the patient's death. HIRS operating hours are Monday to Friday business hours.

2.3 Clinical Governance Unit Responsibilities:

Patient Safety Team

- Creates Death in Custody (DIC) container in Content Manager.
- Coordinates the review of the death in accordance with the requirements of PD2020_047 NSW Health Incident Management and the Health Administration Act 1982.
- Coordinates and leads the PRA on all deaths within 72 hours to determine any immediate risk and review methodology.
- Coordinates and submits a Reportable Incident Brief (RIB) to the MoH for confirmed Harm Score 1 deaths and Harm Score 4 deaths that require a SAER.
- Notifies the Director Aboriginal Health of any death of an Aboriginal or Torres Strait Islander person.
- Notifies the Director of Communications of a patient's death.
- Notifies the Commissioner of Corrective Services NSW in writing of a death in custody.

2.4 Health Information and Records Services (HIRS) Responsibilities:

- Makes an authorised electronic copy of the complete electronic and paper record.
- Provide copies of the health record to the Clinical Governance Unit Patient Safety Team and Legal advisor as soon as practical on request.

2.5 Assessment and Certification of Life Extinct

The assessment of the extinction of life is a clinical assessment process undertaken to establish that life is extinct. By evaluating cardiac output, neurological signs and respiratory status, a registered medical practitioner or RN can establish that life is extinct. This assessment must be documented on a Justice Health NSW JUS010.515 *Life Extinct Form*.

This applies even if CSNSW officers/YJNSW staff have commenced CPR before nursing staff arrive at the incident.

For patients in cardio-pulmonary arrest, resuscitation attempts must be undertaken whenever there is a chance of survival, however remote, unless an Advanced Care Directive is in place – see NSW MoH Guidelines GL2021_004 *End of Life Decision Making*. It is possible in some circumstances to identify patients that there is no chance of survival, and where resuscitation should not be attempted as it would be futile. Such conditions include massive destructive injuries of the head and/or torso, decomposition, incineration, hypostasis and rigor mortis. This applies even if CSNSW officers/YJNSW staff have commenced CPR before nursing staff arrive at the incident.

2.6 Certification of Death

All deaths in custody (DIC) and mental health facilities as defined by PD2024_036 NSW Health Coroners Cases and Coroners Act 2009 (section 3.2) are reportable and investigated by the Coroner. A Death Certificate cannot be issued by a Justice Health NSW medical officer or any other person. The Coroner will issue the Death Certificate following his/her examination of the deceased. The attendance of the Coroner's representative or NSW Police at the scene will be arranged by CSNSW/ YJNSW in accordance with their own policies. Within the Forensic Hospital, during business hours the attendance of the Coroner will be organised by the SDFH or delegate and after hours by the FH- AHNM.

2.7 Scene of death

The scene of a death is a crime scene and any material/items (e.g. bedding, linen) that were initially present at the scene must not be removed. All efforts must be taken not to disturb the scene until it has been examined by the NSW Police on the behalf of the Coroner or until advised by the Police that it is permissible to do so.

Justice Health NSW staff must be aware that all reasonable steps must be taken to preserve the scene. Equipment attached to/entering the body such as drains, intra-venous cannula, endotracheal and intragastric tubes and single use/disposable items attached to these, such as IV fluid bags, syringes, drainage bottles and so on, must be left in situ.

Equipment used to operate/drive these such as IV pumps, oxygen equipment and so on, can be detached and retained at the health centre/ hospital. Emergency response bags associated non disposable equipment, and unused disposable equipment can be retained at the health centre/ hospital. Nursing Unit Manager/Nurse in Charge (NUM/NIC) is responsible for ordering equipment replacements for the emergency back packs.

All sharps or pieces of equipment left in situ must be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised.

If any material and/or vomitus is removed or suctioned from the airway or stomach, this must be retained and placed in screw-capped container(s) (i.e. V-VAC bottle and cap) appropriately labelled and forwarded with the body. Standard infection control precautions must always be observed.

2.8 Notification

All patient deaths are considered to be a reportable incident and must be notified immediately. Prior to notification of the death via Justice Health NSW Executive Group Page system, the appropriate General Manager (GM) must be advised.

The following format must be used when notifying the death via the Executive Group system:

- DIC or Death in mental health facility or,
- If the death was expected, “expected death”
- Site (add name of institution also if hospitalised in a non-Justice Health NSW facility)
- Date and time of death
- First 2 initials of first name
- First 2 initials of Surname
- MIN/CIMS Number/MRN
- Aboriginal status
- Situation - suspected cause of death e.g. hanging in cell, terminal disease or unknown.

The Executive Group Page must not occur until the appropriate GM, has notified the CE and briefed them on the events surrounding the death.

The patient’s death must be notified as a clinical incident in ims+ and the ims+ reference number recorded in the patient’s health record. This must be completed as soon as possible following the death to enable the Clinical Governance Unit to complete the Reportable Incident Brief (RIB) for submission to the CE and Ministry of Health. For deaths involving organ donation, notification must be made at the time neurological death is officially declared. The following information must be included in the incident description if applicable:

- Time called to incident
- Time arrived at incident
- Description of scene
- Assessment of a patient
- The last time the patient attended the health centre
- Relevant medical history
- Relevant medical treatment, including medications
- Description of all actions taken
- Other actions e.g. CPR commenced, Ambulance called etc.
- Aboriginality
- Whether the person was residing one out, two out cell etc.
- Whether the person was on remand, sentenced etc.
- Date reception screening was completed

The Clinical Governance Unit is required to submit a RIB via ims+ to MoH within 72 hours of the incident occurring. The RIB will only be submitted following approval by the Chief Executive.

For deaths which occur in Privately Operated Correctional Centres the Justice Health NSW Risk and Assurance team should be advised once the death has been notified in the ims+.

2.9 Documentation

Justice Health NSW staff members in attendance must document the events surrounding the death in the patient’s health record. The assessment for life extinct must be recorded and documented on JUS010.515 *Life Extinct Form*.

The assessment must contain the time and details of what actions were taken e.g. CPR commenced, or CPR not commenced because and provide the clinical rationale.

Document clearly the reasons for decisions, the duration of emergency care and the reasons for terminating it.

Record any relevant clinical details of the death, either from witnesses and/or observation of the scene. This may include a description of the scene, for example:

- "Syringe found in hand"
- "Note found"
- "Patient found clothed lying on bed"
- "Patient found with sheet around neck."

Justice Health NSW staff members, as with members of the public, have an obligation to cooperate with the Police. NSW Police may request the staff of Justice Health NSW to provide a written statement. Justice Health NSW staff should not make a statement to the police without seeking prior advice from their manager and Justice Health NSW Legal Advisor.

Justice Health NSW Legal Advisor will coordinate with NSW Police any required interview/statements. Where staff are contacted directly by the NSW Police or other difficulties arise, staff must contact their manager, AHNM, or Legal Advisor for further advice.

2.10 Health Record

Staff members must not provide any Justice Health NSW records to NSW Police. An authorised copy of the electronic and paper health record will be provided to the Police on receipt of an order pursuant to s53 Coroners Act 2009.

Authorised copies may only be made, and provided to NSW Police, by HIRS.

The NUM or delegate must ensure that the original health record is sent to HIRS as soon as possible. Records must be sent to HIRS by Justice Health NSW courier during business hours. Upon receipt of the original health record HIRS staff will make an authorised electronic copy of the electronic and paper record, complete and attach the Pro forma for the Coroner CNS509 form and create a volume within the (Patient Administration System (PAS) to identify that a copy of the health record exists. HIRS shall provide an electronic copy to the Legal Advisor and to the Program Manager Patient Safety within seven days (HIRS must retain an authorised electronic copy of the health record).

2.11 The Commissioner's Report

In line with the Crimes (Administration of Sentences) Regulation 2014 section 291, on becoming aware that an inmate has died the Director Clinical Governance (DCG) as authorised by the Chief Executive (CE) will notify the Commissioner of CSNSW or Executive Director YJNSW.

For deaths within NSW privately managed correctional centres, private operators will prepare the Commissioner's Report and submit to the Commissioner of CSNSW.

The Commissioners report will include a brief background of the person's health history, age, location, time and date of death and Aboriginality.

2.12 Debriefing

Debriefing must be arranged by the Nursing Unit Manager for staff directly involved with the death and may be necessary for other staff not on duty at the time. In these circumstances please refer to Justice Health NSW procedure 8.018 *Employee Assistance Program* and

identify individual support needs. Additionally, it may also be necessary to organise debriefing of other patients in situations where the death was witnessed or with whom the deceased had a significant relationship. These patients are best referred to CSNSW/YJNSW welfare and psychology services for additional support and debriefing, including social work or psychologists in the Forensic Hospital.

2.13 Investigation

Investigation of deaths of Justice Health NSW patients is governed by the MOH PD2020_047 *Incident Management*.

2.14 Coronial Inquiry

All deaths in custodial and mental health facilities are investigated by the Coroner. When a matter has been listed for a coronial inquiry, the Coroners Court will notify the Justice Health NSW Legal Advisor. If the only witness called is the Officer In Charge (OIC), or if the witnesses being called are from CSNSW/YJNSW, and there are no witnesses from Justice Health NSW only the Legal Advisor will attend the inquest. If there are witnesses called from Justice Health NSW and/or contentious issues identified, the Legal Advisor shall brief the matter to external lawyers subject to notification to MoH. The Legal Advisor will contact the witnesses to advise that the Police will be requesting them to provide a statement and offer any necessary support.

If staff are contacted directly and are requested to appear before the Coroner, they must advise Justice Health NSW Legal Advisor and their line manager in the first instance.

A copy of the relevant health record shall be made available by the Justice Health NSW Legal Advisor for staff to peruse prior to drafting a statement. Prior to providing a statement, staff will have an opportunity to seek legal assistance from their professional union/association should they so desire. If staff are not assisted by their union, they must seek assistance from the Justice Health NSW Legal Advisor for support and to have their statement checked. Staff should at all times be provided with support and guidance by their line manager.

2.15 Open Disclosure

High level open disclosure is offered for all Harm Score 1 incidents, and is coordinated by the Clinical Governance and Innovation Unit in accordance with the Ministry of Health PD2020_047 *Incident Management* and MoH PD2023_034 *Open Disclosure Policy*.

2.16 Media Interest

Some patient deaths may lead to media and/or public interest and must be managed through the Communications Unit in accordance with Justice Health NSW policy 2.018 *Media and External Communications*.

2.17 More Information and Assistance

Any concerns/queries regarding deaths must be directed to the Justice Health NSW Legal Advisor or the Clinical Governance Patient Safety Team.

3. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

4. Related Documents

Legislations	*Health Administration Act 1982* *Coroners Act 2009* *Voluntary Assisted Dying Act No.17*
Justice Health NSW Policies, Guidelines and Procedures	2.018 *Media and External Communications* 5.017 *Management of Emergencies – Forensic Hospital* 8.018 *Employee Assistance Program* 7.013 *Voluntary Assisted Dying Implementation Guidelines*
Justice Health NSW Forms	JUS010.515 *Life Extinct Form*
NSW Health Policy Directives and Guidelines	PD2023_034 *Open Disclosure* PD2024_036 *Coroners Cases and Coroners Act 2009* GL2021_004 *End-of-Life Care and Decision-Making* PD2020_047 *Incident Management* PD2023_014 *Verification of Death and Medical Certificate of Cause of Death*
Other documents and resources	ims+ Classification Guidance *Unexpected death in custody in private correctional health centres* 13.03 *Death in Custody Custodial Operations Policy and Procedure*