LIFE WITHOUT BARRIERS

Responding to a Client Death

Policy Guideline

1. Policy Objectives

To guide LWB employees' responses where a client death occurs by:

- Ensuring all reportable deaths (see definition "Reportable or Reviewable deaths" below) of people receiving a service from LWB are reported in line with the client death procedure.
- Ensuring the cultural and religious beliefs and practices of people are respected, including planning with family and community members prior to a person's death.
- Responding to the death of a client in a sensitive, dignified, and prompt manner, while meeting contractual and legislative reporting requirements. This may include reporting to State Coroner, Ombudsman, The NDIS Quality and Safeguarding Commission and funding bodies.
- Delivering clear and respectful information to family members, friends, guardians, or advocates.
- Assisting and supporting family members, guardians, advocates, other clients, carers and LWB employees.
- Responding appropriately to requests for information as part of an investigation by external agencies, such as Ombudsman or Coroner.
- Understanding the Client Death Review Process.

2. Client Death Procedure

The following process should be followed for client deaths who received a service where LWB has a high level of responsibility.

2.1. Immediately after a death:

- Inform the police of the death.
- Advise the Police that the death is reportable under the relevant State Coroners Act even if death occurs in a hospital.
- For people receiving a disability service where the death occurs in hospital, inform the doctor in charge not to issue a death certificate as the death may be reportable under relevant Coroners Act as a death in care.
- Retain a record of the name, rank, and station of the attending Police officer.
- Do not disturb the scene of the death or the body of the deceased before the Police attend.
- Notify line manager or on-call manager if after hours.
- NISS - for NISS clients, a verbal report must be made to NISS National, or on-call if after hours, within 15 minutes after safely responding to the incident. Ensure the Department of Home Affairs Incident Report protocols and internal procedures are followed – as outlined in the NISS Operations Manual - Incident Management and Reporting Guideline.

2.2. Response required within 1 to 2 hours of the death

- If the person was receiving palliative care, see Factsheet - Palliative Care.
- Cooperate with police requests for witness statements or documentation. Police will report Reviewable/Reportable deaths to the appropriate coronial body. Workers being interviewed by police should be supported by the senior workers/managers available at the time.
- Notify next of kin or guardian
    - Immediately following a person's death, determine whose role it is to inform the family. This should include discussions with line managers and where appropriate, the statutory agency. If LWB is responsible for notifying family, they must be notified immediately if they can be reasonably located. Where possible, this should be done in person. Note: Police will often take responsibility for notifying family.
    - For culturally appropriate information about contacting next of kin see Client Death Cultural Care Fact Sheet – Aboriginal and Torres Strait Islander People.

2.3. Response required within 24 hours of the death

- Update LWB systems as per 'Updating LWB client records' section below.
- **CYF** – For children in statutory or supported out-of-home care in NSW, the Office of the Children's Guardian, the Coroner and Community and Justice Services (DCJ) must be notified within 24 hours of the death.
- **Disability & COS** - in collaboration with Client Services, the NSU team will assess the event and data recoded in i-Sight and CIRTS to determine if a notification is required to be made to the NDIS Commission. The initial notification to the commission must be made within 24 hours and a further update is provided 5 business days later. This is consistent with all reportable incidents and not specific to client death. Depending on the circumstances of the client death or if the reportable incident contains an allegation of harm from staff or client to client, the NSU will seek advice from the NRAIT team as to whether an internal investigation is required.
- For further information on Reportable Incident process and procedures contact the NSU team or refer to the following materials on NDIS sites:
    - How to notify the NDIS Commission about a reportable incident | NDIS Quality and Safeguards Commission
    - Incident management and reportable incidents (NDIS providers) | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)
    - The 'Reportable Incidents Guidance' developed to support the NDIS Quality and Safeguards Commission Rules.
    - My Reportable Incidents – Frequently Asked Questions | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)
- **Notify the Coroner** - LWB must notify the Coroner of reportable deaths even if the person died in hospital and someone else may have reported it. Phone the Coroner's office to seek advice about whether the death is reportable.
    - NSW: Contact us
    - QLD: Contact us
    - SA: Contact us
    - VIC: Contact us
    - NT: Contact us
    - TAS: Contact us

2.4. Response required within 48 hours of the death

- The management team will develop a strategy to complete the following tasks, clearly identifying a senior staff member responsible for completing or overseeing tasks.

2.5. Response required within 48 hours of the death or after

- Provide support for other clients, carers and employees.
- Assist employees and carers to provide witness statements to the police where requested.
- Provide bereavement support, see 'Bereavement Support' section.

2.6. Additional notes

Where LWB becomes aware of the death of a client, who dies within 2 years of ceasing their LWB service, the death should be recorded in i-Sight and follow the Client Death Review process. This includes children and young people, and people who received a service where LWB had a high level of responsibility.

Aged Care - Where LWB staff find a person receiving an aged care service unresponsive or deceased, or where an aged care person suffers a medical emergency resulting in death while LWB staff are providing services follow the procedures in this guideline.

- The death should be recorded in i-Sight.
- It should follow the Client Death Review process.
- In addition, for any person receiving an individual aged care package notify the relevant funding body within 14 days.
- Should there be any suspicious circumstances for e.g. suspected neglect, abuse, report this to the Quality and Safeguarding Commission.

3. Management Accountability

3.1. Operations Manager

- Provide advice and support to complete the next steps including who notifies next of kin or guardian.
- Inform the relevant senior managers.
- Ensure staff who contacted the Police retain a record of the name, rank and station of the attending Police officer.
- If Police require LWB to identify a deceased person, confirm who will undertake this task and ensure they are supported.
- If Police request a person's records, ensure a copy is made and kept by LWB in a secure location, such as a locked filing cabinet.
- Ensure the death is reported, regardless of the circumstances of the death, and including a death that occurred in a hospital.
- Ensure the event has been logged in i-Sight.

3.2. State Directors / National Managers

- Coordinate support to the Regional Manager.
- Confirm the event has been logged in i-Sight and actions resulting from the incident are completed.
- Brief the relevant ExecutiveTeam member as required.

3.3. Deputy Chief Executive

Notify the Client Death Review Panel immediately if the level of risk identified is 'critical'.

More information about notification tasks and responsibilities in response to a client death is provided in Appendix A. The Client Death Review Panel notification tasks and responsibilities allocated to the associated LWB positions that are responsible, accountable, consulted, or informed (RACI) is provided in Appendix B.

4. Updating LWB Client Records

- Close and secure all paper files.
- i-Sight:
  - Log the client death as an incident if not already completed.
  - Attach evidence of any relevant obligatory reporting documents and timeframes.
  - Record the death expectancy consistent with the Expected and Unexpected Death definitions provided in in this document. This may require checking the diagnostics in CIRTS.
  - Enter the Review Details, this is name of the person in NSU or Client services performing the initial review consistent with all reportable incidents.
  - Follow up any actions listed in i-Sight to manage and close the event.
- **CIRTS:**
  - Enter the Date of Death.
  - Continue to enter case notes to the CIRTS file, making sure it is up to date with all actions in response to the clients death and following the clients death; such as details of the incident, any family contact, contact with external agencies, funeral arrangements, staff support, and all other actions taken in relation to the death.
  - Close out the record, including changing the status of the CIRTS file from active to inactive. See "Closing a client file" in Definitions below for more information.

5. External Reporting Requirements

- Immediately report all deaths to the police.
- It is important to note, that some of our clients may receive supports or services across multiple LWB programs. Where a client receives NDIS supports and is also a client in our CYF program, LWB is required to report externally to both funding bodies, as well as oversight bodies.

- Nominate a primary contact person for external agencies, excluding formal reviews e.g. Coroner or Ombudsman and NDIS Commission.
- For more information see Appendix A – external reporting requirements.

6. Response to External Requests for Information

- Forward any requests by external agencies to formally review a person's death to the State Director. This includes requests by funding agencies, State Government Child Death Review Teams, Ombudsman, Coroners and the NDIS Commission.
- The State Director is to ensure human resources and support is provided as necessary. This includes copying and reviewing files prior to responding to the request.
- For Coronial Inquests or other formal reviews, the State Director is to notify the relevant Deputy Chief Executive, the National Manager Practice and Quality, Legal Counsel and Commercial and Legal Services as soon as possible. The relevant Deputy Chief Executive will notify the Chief Executive.
- Full and unrestricted access to relevant records relating to reviewable deaths must be provided to relevant oversite bodies as requested, following review and support from LWB's Legal Counsel.
- See Appendix A for more information about external reporting requirements per sector and State.

7. Bereavement Support

Grief is a normal response to loss and can occur at any time, even before the person dies. People experiencing grief may need support.

Where the deceased person lives in an LWB residential home or attends a day program, LWB staff may be the most appropriate people to tell other residents or clients about the death. Prior to doing this, a nominated senior staff member should ask the deceased person's family for consent to inform others about the person's death and how they would like it done.

7.1. Supporting the family

- Respond to family and friends in a prompt and dignified manner.
- Respect and be sensitive to cultural and religious beliefs and practices of the person and family. See Client Death Cultural Care Fact Sheet – Aboriginal and Torres Strait Islander People for further information.
- Where LWB is responsible for accommodation support, leave the deceased persons' bedroom intact so that family, friends, and support workers can visit should they wish.
- Assist with funeral arrangements on a case by case basis.
- In some programs it may be appropriate to maintain contact with the family after the funeral. This is particularly important if family were actively involved in a service or program and had formed relationships with other people in the service, their families and support workers.

- If action has been taken to improve service as a result of a person's death, provide relevant information to the family (this should be done by a senior staff member).

7.2. Supporting front line workers

Operations Managers are responsible for support to front line workers affected by the death of a person. This might involve individual counselling or group debriefing, as well as giving workers the opportunity to talk about how they feel immediately after the event and over time.

Debriefing can be done by managers, clinicians or a skilled counsellor. Formal debriefing and counselling is available through the Employees Assistance Program (EAP). Details of EAP are to be provided to affected staff following a person's death, and at any time following the death of a client where the need for additional support is identified. For more information about this free service see information about your EAP service.

7.3. Supporting other people in the residence service or program

This should be assessed on a case by case basis. Consider the needs of house mates and friends from day programs or other groups. This may include counselling services and resources to guide workers when considering how to work with others who are affected by the death. General guidance includes:

- Be honest, include and involve the bereaved person.
- Listen to and be present for the bereaved person.
- For people with disability consider their individual communication needs, nonverbal rituals, minimise change and routine. Seek specialist help if behaviour changes persist.
- Respect photos and mementos the bereaved person may have.
- Support the observance of anniversaries.

8. Post Death Requirements

8.1. Cultural and linguistic diversity

Cultural sensitivity is important. Each person and family is unique and it is important to understand the family's needs following a death. This may require the use of an interpreter.

- Before making any arrangements, it is important to know whether the deceased person had an Advanced Care Plan/Order/Directive in place to contact the contact person named in the plan.
- Where no end of life, Advanced Care Plan/Order/Directive has been made, it is still important to talk to the family to understand any rituals, ceremonies, or taboos around the death of a person.
- The primary LWB contact person could seek information from the family such as:
  - spiritual and religious beliefs, practices, and taboos they wish to observe
  - how the family communicates, the need for an interpreter, the acceptability of certain words when discussing death or illness.

8.2. Aboriginal and Torres Strait Islander People

- Aboriginal and Torres Strait Islander people may have customary practices before and after a person has died. See Client Death Cultural Care Fact Sheet – Aboriginal and Torres Strait Islander People for further information.

8.3. Funeral arrangements

- Families or an alternative decision maker are generally responsible for arranging the funeral. If the person has an End of Life Care Plan or an Advanced Care Plan/Order/Directive that outlines funeral wishes, this should be followed.
- If the deceased person does not have family, a guardian or advocate, the management team develops a plan that identifies staff members responsible for arranging the funeral and advising friends, work associates, and other service providers of the funeral. This may be in partnership with other agencies where multiple agencies are involved.
- In cases where the family cannot afford the cost of a funeral, and a person's estate cannot cover funeral costs, a referral can be made to the local police and/or the local Aboriginal Lands Council.
- LWB staff attendance at funerals should be in consultation with family members, with respect given to family decisions, and in consultation with line managers where personal leave is required.

8.4. Estate management (where LWB provides accommodation support)

- If the person had a will, the person's solicitor or executor will manage closing the person's financial affairs.
- If the person does not have a will, seek advice from the relevant Public Guardian or Trustee:
  - Victoria – Victorian State Trustees
  - Queensland – Public Trustee of Queensland
  - Western Australia – Public Trustee
  - South Australia – Public Trustee
  - Tasmania – Public Trustee
  - ACT – Public Trustee
  - NSW – Public Guardian
  - Northern Territory – Public Guardian

8.5. The deceased's bedroom and assets (where LWB provides accommodation support)

- If the deceased person lives with other people, secure their belongings by closing or locking their door. Do not remove anything from their room until instructions are given by the family, trustee, guardian, or executor.
- Do not clean or change the deceased person's room as their family, friends or support workers may wish to spend time in the room as part of the grieving process.

- After the funeral, complete an asset stock take against any existing asset registers. Store the deceased person's belongings securely until further instructions are given by the family, trustee, guardian, or executor. Place a copy of the assets stock take and asset register with the belongings and a copy on their CIRTS file.

9. Client Death Review

LWB reviews the death of all people who die while receiving a service in the sectors listed below. This includes people who are temporarily absent from a service, i.e. in hospital, staying with family.

- Child, Youth and Family (CYF)
- Disability
- Mental Health
- NISS
- Homelessness

The Client Death Review Panel will also review the deaths of some people who die within two years of leaving an LWB service.

For further details about the Client Death Review process see the Client Death Review Process document.

10. Definitions

For more definitions, please see LWB's National Glossary.

- **Advanced Care Plan/Order/Directive:** A doctor or another health professional may recommend a person consider making an advanced care plan when they still have capacity to make decisions that will affect their care at a later stage when they no longer have capacity. In some states and territories, the advance care directive is referred to as an advance health directive or a Living Will.

Note: A person who has never had capacity to make decisions about their health or medical treatment cannot develop an Advanced Care Directive or Living Will.

- **Client Death Review Report:** The report submitted to the Client Death Review Panel.
- **Client Death Recommendations:** Actions agreed as a result of the Client Death Review Panel.
- **Client Death Review Panel:** A LWB panel established to review the circumstances of all client deaths.
- **Client File:** All documentation kept by LWB in the deceased's name, including (where applicable):
  - client office file
  - client house file (if in a residential service)
  - carer diary
  - CIRTS information

  - National Incident Register information (i-Sight)
  - Staff communication book.
- **Confirmed Death:** A formal pronouncement by an attending medical officer.
- **Closing a Client file in CIRTS:** Closure of all documentation in the deceased's name (please note: CIRTS National Business Rules must be applied).
  - Close out the person's CIRTS record including changing the status from active to inactive within the first 48 hours of the client's death.
  - Continue to record the actions in responding the client's death in CIRTS until all activity is complete, e.g. funeral arrangements, liaison with family and external agencies, staff support, provision of information to Police, Coroner, and/or Ombudsman.

Note: CIRTS information will be accessed for client death reviews. If further information is required, this will be requested. Ensure all paper based records are secured and stored as they may be requested later by an external agency such as a Coroner, Ombudsman or the NDIS Commission. Where police request files, ensure a copy of all documents given to police is kept.

- Death Expectancy:
  1. **Unexpected:** When a person dies suddenly, unexpectedly and earlier than anticipated, even in palliative care.
  2. **Expected:** When a death is a direct consequence of a specified life-limiting illness. Such illnesses may include, but are not limited to cancer, heart disease, chronic obstructive pulmonary disease, dementia, heart failure, neurodegenerative disease, chronic liver disease and renal disease.
- **End of Life Care:** Refers to the person centred planning process a person can participate in to determine their preferences and wishes as their life ends and includes their friends and family, environment, wishes for funeral and burial / cremation arrangements.
- **i-Sight:** LWB's National Event Management System used for the recording, management and review of Client Incidents, including risk of significant harm and reportable conduct allegations.
- **Palliative Care:** The care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary treatment goal is to optimise the quality of life.
- **Reportable or Reviewable deaths:** All client deaths receiving a service from LWB in CYF, Disability, Mental Health, NISS and Homelessness sectors are reportable to and reviewable by LWB.
- The following LWB client deaths are also reviewable by or reportable to external agencies:
  - child in care
  - person (whether or not a child) living in residential care operated by a service provider authorised or funded by a Disability Service, including those funded under the NDIS trial

- person (whether or not a child) living in a residential centre for mental health clients (or was temporarily absent from such a place)
- person with a disability (other than a child in care) in receipt of assistance living independently in the community
- person with mental health diagnosis (other than a child in care) in receipt of assistance living independently in the community
- person receiving a service in the NISS programs.

Note: the term “residing in or temporarily absent from” refers to permanent residents of accommodation facilities. If the resident dies while temporarily away from the service i.e. whilst in hospital, on holiday, with their family or in respite care, reporting of the death by LWB is still required.

11. Acronyms

For more acronyms, please see LWB’s National Glossary.

- **RACI:** responsible, accountable, consulted, or informed.
- **NSU:** National Safeguarding Unit.
- **NRAIT:** National Reportable Allegations Investigations Team.
- **COS**: Continuity of Support.
- **OM:** Operations Manager.
- **RM:** Regional Manager, also referred to as Regional Director.

12. Audit / Evaluation

- The LWB client death review process confirms that client deaths are reported and responded to according to the Death of a Client Guideline.
- All client deaths are monitored or reviewed by the Client Death Review Panel.
- Recommendations of the Client Death Review Panel are placed on a register, progress monitored and reported.

13. Appendix A: External Reporting Requirements per Sector

1. Disability (NDIS and COS Funded) All States	Responsibility	Timeframe
Immediately report all deaths to the police.		
Notify the NSU team following the Reportable Incident process and procedures.	Regional Manager	
Notify the NDIS Commission as required following the NDIS Commissions Reportable Incident Guideline.	NSU Team	Within 24 hours
Notify the NDIS Funding Body by emailing the local NDIA office.	Operations Manager	Within 48 hours
Deaths of people in care must be reported to the Coroner.	Operations Manager	ASAP
2. NISS (For people receiving Band 2 - 6 funding)	**Responsibility**	**Timeframe**
Immediately report all deaths to the police.		
Notify LWB NISS National Office by phone – LWB NISS National Office or On-Call if after hours.	NISS National Office	Within 15 minutes
NISS National to notify Department of Home Affairs (DHA) by phone - DHA Incident Hotline on 1800 177 105, option 3.	NISS National Office	Within 30 minutes
NISS National to email National DHA via DHA Operations Inbox.	NISS National Office	1 Hour
Complete a written incident report to LWB NISS National Office using the Incident Report	NISS National Office	Within 4 business hours

NISS National Office to check the incident report and forward to the relevant DHA band email address.	NISS National Office	Within 8 business hours
3. **CYF per State**	**Responsibility**	**Timeframe**
Immediately report all deaths to the police.		
• NSW (including foster care and ITC)	**Responsibility**	**Timeframe**
• Police: Formal written notification to Local Area Command (LAC). Include name, DOB, Legal status, Date and place of death, address, length of stay at address, type of facility i.e. foster care, ITC, program or service, citing notification is being made under the Children and Young People's Care and Protection Act 1998, Coroners Act 2009, details of person making the notification	• Signed by State Director	• Within 48 hours
• **NSW Coroner:** The Coroner is notified by the Police. However, LWB must still separately send a formal letter (see details to NSW police above) via email or letter to: • NSW State Coroners Court 1A Main Avenue Lidcombe NSW 2141 • lidcombe.coroners@justice.nsw.gov.au	State Director	Within 48 hours
• Department of Communities and Justice (DCJ) • Verbal report to the Helpline 132111 Inform the relevant DCJ Contract Manager and Serious Case Review Manager both verbally and in writing (see letter to NSW police above).	Staff/carer present, staff/managers who the event is directly reported to.	Immediately
• **NSW Office of the Children's Guardian:** Verbally notify the Manager, Accreditation and Monitoring on (02) 8219 3606 In writing by completing the Death of a child and young person in statutory out-of-home care notification form. Email the form to: oohcnotifications@kidsguardian.nsw.gov.au	State Director	Immediately

NSW Ombudsman: Generally, where a child died as a result of an alleged reportable conduct incident directly notify the Ombudsman as per the usual reportable incident scheme, via deathreviews@ombo.nsw.gov.au	State Director (ICU facilitates this)	Within 48 hours

• For a child/young person with a disability in OOHC notify the Ombudsman by using the relevant form:
  • Client Death Notification Form NDIS
  • Client Death notification Form DCJ
  • Client Death Notification Form ABH (Assisted Boarding Houses)
Email form to deathreviews@ombo.nsw.gov.au
	Regional Manager	Within 48 hours

See NDIS section for children who receive NDIS funding.	Regional Manager	Within 24 hours.
QLD	**Responsibility**	**Timeframe**
• **Department of Children, Youth Justice and Multicultural Affairs:** Immediately provide a verbal report to relevant Child Safety Service Centre. During normal business hours: Regional Intake Services contact. If after hours report to Child Safety After Hours 1800 177 135. Use the online reporting tool.	OM / Program Manager	Immediately
Provide a copy of the written report from i-Sight within 4 business hours, or as soon as it is reasonable to do so, and as soon as the immediate safety and wellbeing of those involved is assured.	OM / Program Manager	
Coroner: Report child deaths to the Coroner where the death has not yet been reported by a medical professional or police. Contact the Coroner to seek advice if unsure. Use the Reportable Death form if a report is required.	OM / Program Manager	
WA (including Family/AYRA/WBEAC services)	**Responsibility**	**Timeframe**

Notify the Department of Communities; Child Protection & Family Support (CPFS) by phone or email to child protection worker (CPW). If CPW not available, notify Team Leader (TL). If TL not available notify District Director.	OM / RM / State Director	Immediately
Provide a written report to the Department of Communities; Child Protection & Family Support – generate an incident report from i-sight.	OM / RM / State Director	Within 24 hrs
NT	**Responsibility**	**Timeframe**
Organisations must report the matter to the Case Manager, Team Leader or Manager from Territory Families. It is then the responsibility of Care and Protection staff to take further action to inform family and authorities and to make funeral arrangements.	OM / RM / State Director	Immediately
TAS	**Responsibility**	**Timeframe**
All service providers must report the death immediately to their line supervisor and to the Case Managing Child Protection team from the Department, regardless of the cause of death. Further, more detailed guidance can be found in the DHHS.	OM / RM / State Director	Immediately
VIC	**Responsibility**	**Timeframe**
Any death in unexpected or unanticipated circumstances, including suicides, must be reported as major impact incidents in CIMS within 24 hours: http://providers.dhhs.vic.gov.au/cims For a child/YP who was a child protection client at the time of death or within 12 months before their death, a copy of the iSight incident report must be provided to the Commission for Children and Young People and the Child Protection Unit, Statutory and Forensic Services branch of the department. For a child who was not a child protection client either at the time or within 12 months before their death, the State Director should consider what action may be required and whether the matter should nevertheless be reported to the department and/or the Commission for Children and Young People. Relevant factors to consider include:		24 hours

• the length of time elapsed since child protection's involvement with the child • the extent of child protection's involvement • the sensitivities of the case • the potential for public, political or legal scrutiny • the particular facts and circumstances		
Justice VIC	**Responsibility**	**Timeframe**
Immediately report all deaths to the police.		
For people in Prevention and Recovery	**Responsibility**	**Timeframe**
Verbally notify Albury Wodonga Health.	OM / Program Manager	Within 1 hour
Provide written notification.	OM / Program Manager	Within 24 hrs
Mental Health WA	**Responsibility**	**Timeframe**
Immediately report all deaths to the police.		
Notify the Mental Health Commission (MHC). An email is automatically generated when Notifiable Incident Form is submitted.		Within 48 hrs
Notify the Office of the Chief Psychiatrist - for Private Psychiatric Hostels (e.g. Ngatti House) accessible immediately if incident may receive attention by media/wider community via http://www.chiefpsychiatrist.wa.gov.au	OM / RM / State Director	ASAP

14. Appendix B: Death Notification Tasks and Responsibilities

Task	Responsible / Accountable / Consult / Inform (RACI*)					
	Frontline employee	OM or equivalent	Director of Operations or equivalent	Chief Executive	National Practice & Quality	National Quality & Risk
1. Report death of a client to Police and LWB line management	R	A	A	I	I	-
2. Complete LWB documentation requirements	R	A	I	I	I	-
3. Support clients, families, carers and employees	R	R	A	I	I	-
4. Report to external organisations regarding the client death	-	R	I	I	A	-
5. Respond to external requests for information regarding the client death	-	R	I	I	A	-
6. Monitor and track required information regarding the death of a client	R	A	I	-	-	-
7. Review circumstances of client death and complete Client Death Review Report	I	C	-	R A	-	-
8. Complete documentation requirements for the Client Death Review Panel	-	R	I	-	-	-
9. Attend Client Death Review Panel	-	-	R	A	R	R
10. Record and monitor recommendations made by the Client Death Review Panel	-	-	I	I	I	R A

*RACI
R =Responsible - Owns the project / problem
A = Accountable - Must sign off / approve on work before it is effective
C = Consult - Has the information and/or capability necessary to complete the work
I = Inform - Must be notified of results, but does not need to be consulted