Death of an Elder

Medical Leader	
Medical Expert	
Communicator	•
Advocate	•
Scholar	
Professional	
Collaborator	•
Manager	•

2014 (November) - DAY 1 – Q5

You are a medical administrator relieving in a regional hospital which serves a community with a large indigenous population.

One afternoon you are confronted by an extended family group who are crying and very angry. They are indigenous people who live some distance from the hospital in a remote community. It seems that their beloved elder died unexpectedly in the early hours of that morning. He had been admitted to your hospital a week previously with an exacerbation of chronic obstructive pulmonary disease. The family had received word that he had shown great clinical improvement and advice that he was able to be discharged today. However, when the family had arrived to pick him up, they were shocked to be advised that he had passed away suddenly early that morning. His bed had been cleaned and remade and his personal possessions packed up in property bags left in the corner of the room.

You are advised that the patient had sustained a fall early that morning, striking his head and had died shortly thereafter. The family are extremely angry that they had not been informed of the elder's passing. They tell you that it is a strong tradition within the indigenous group that the dead are never left alone during the formal mourning process. However, because this patient had died unexpectedly following a fall, the Coroner was notified and an investigation instigated and the body had been removed for post-mortem examination.

You investigate and find that night staff did not try to contact the family at the time of death and that the morning staff were unable to contact them because the family was in transit from the remote community. You share this information with the family but they are not appeased.

Questions

- What issues does this raise for you on the immediate management of the situation and for the organisation in the longer term?
- How do you manage this situation?

Guidance for Censors:

ISSUES

1. **Cultural competency.**
2. **Indigenous liaison services.**
3. **Processes / policies regarding care of the deceased.**

- Apologise to the family; find them somewhere comfortable and private to wait while you try to find out more of the circumstances. Offer them the use of telephone and refreshments. Ask if they need cultural and spiritual support and arrange for these needs to be met as quickly as possible.
- Inform your CEO, communications advisor and indigenous advisor. Consider whether the Minister / Ministry should be advised. Depending on the local culture and media availability, consider statement acknowledging the death and confirming the coronial investigation (? Police responsibility)
- Contact the Coroner's office to explain what has happened and request that the post mortem be carried out with the least possible delay.
- Contact the senior clinician responsible for the patient's care. Request or complete a formal incident report through the organisation's risk reporting system and request the immediate investigation into the sequence of events leading to this gentleman's death.
- Ensure all records are preserved and arrange for staff involved in the care to prepare statements.

Medium term:

- Review policy concerning care of the dead, including notification of the family. Does the policy include specific direction regarding the indigenous group; has it been approved through indigenous liaison?
- Review incident reports and complaints to see if there have been any similar events reported, looking for evidence of both culturally incompetent behaviour from staff and/or inappropriate care of family including issues with notification following a death.
- Keep in contact with the family and arrange to meet with them and their support people at a time of their choosing following the funeral / tangi. Open disclosure of findings of your investigation and any remedial steps taken. Ask for more information about allegations of culturally insensitive or poor care and invite them to participate in any review that you and they identify as needed, or invite them to nominate suitable participants from their indigenous community.
- Discuss with the Coroner ways of respecting cultural traditions that may be achievable within the legal framework of the coronial investigation,

- Review training and orientation provided to clinical staff (particularly locum or inexperienced staff) on the management of indigenous clients.
- Support for clinical staff who have been involved in caring for the patient including advice on preparing statements for the Coroner.