

Managing Death in the Operating Theatre

Key Points

- Inform the on-call or troubleshooting consultant in the event of a death on the operating table.
- Give consideration to leaving lines, endotracheal tubes, and equipment in-situ, and keeping the drugs administered, especially in unexpected deaths.
- Record the events surrounding the death in the medical record as soon as possible.
- The relatives should be spoken to by senior staff, in a sensitive manner.

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Abbreviations

AD	Associate Director
ET	Endotracheal
M&M	Mortality and Morbidity
MHRA	Medicines and Healthcare Regulation Agency
NPSA	National Patient Safety Agency
SUI	Serious Untoward Incident

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1.0 Immediate actions

1.1 Personnel

For Residents and Speciality doctors, a responsible consultant anaesthetist (on-call consultant/admin consultant/starred consultant/5639 consultant) should be notified immediately and should attend in person. For consultants involved in unexpected deaths, inform either the 2nd on-call consultant or the (Deputy) Clinical Director, who may attend if available to assist with the aftermath, depending on the circumstances.

The (Deputy) Clinical Director for both anaesthesia and the relevant surgical specialty should be informed as soon as is practical. Again, the time-scale for this depends on the circumstances of the individual case.

A decision must be made as to whether the anaesthetist, and any other staff involved, should continue with their on-call/list, and this should be judged after discussion between the anaesthetist involved and senior colleagues.

If the death occurs during an elective list, consider whether the remainder of the list should be cancelled, or completed by a different anaesthetist, theatre, and surgical team.

1.2 The patient

Consider leaving all lines, tubes, and equipment connected to the patient, including the endotracheal tube, in-situ, particularly in unexpected deaths. If there is any doubt as to the position of the ET tube this should be verified and documented by a second anaesthetist. If available, consideration should be given to keeping drug ampoules and syringes, particularly if there is any doubt about the circumstances of the death. If kept these should be stored in such a fashion as to minimise the risk of sharps injury, for example in a clean sharps bin. A record should be made of all drugs administered, the dose, expiry date and batch numbers.

Any surgical incisions should be closed, dressed and then the patient transferred to the recovery area. If relatives wish to view the body, they should be afforded adequate privacy and support from a designated member of the nursing staff throughout.

1.3 Documentation

Record all events promptly and legibly, with all entries timed, dated, and signed.

If the anaesthetist is unable to write notes immediately then a full retrospective account must be made as soon as possible.

Do not alter any original notes and charts at later date. Any changes later must be recorded separately and signed. These should be made as retrospective entries rather than amending existing documents.

1.4 The relatives

Breaking bad news should not be done via telephone. The next-of-kin should be asked to attend the hospital and given clear instruction regarding where to report to.

Relatives should be spoken to by anaesthetic and surgical consultants, accompanied by a member of the nursing staff. Do not talk to them alone.

Offer Pastoral Holistic support (faith and non-faith) to the relatives, which is available out of hours via Switchboard.

They should be spoken to in a private area free from interruptions. Be open and honest, and apologise, even if no error has occurred. Inform them that there will be further investigation of the events surrounding the death of their relative.

Contact Hospital Bereavement service.

2.0 Subsequent actions

2.1 Report the death

Deaths during an operation must be reported to the coroner. This is usually the responsibility of the surgical team but can be done by any senior clinician. If there is any suspicion of a criminal act the police should be informed immediately.

The surgical team must ensure that the patient's GP is informed of the death.

The death must also be reported within the Trust, using the Incident Reporting system. Please also inform the departmental M&M leads.

If a trainee is involved in the death, ensure that the College Tutor has been informed.

Ensure that the (Deputy) Clinical Director is made aware if they have not already been informed.

2.2 Personnel

An immediate debrief should be held with all members of staff involved in the death, preferably within a few hours of the death occurring. This should be led by the consultant clinician. The aim of this is to provide and record information, and to gain feedback, whilst memories are still fresh. It is also useful to allay anxieties or misconceptions experienced by members of the theatre team. Appropriate emotional support should be provided to all members of staff involved in the death.

A further 'cold' debrief in the days/weeks after the event may be helpful in some circumstances.

2.3 Equipment and drugs

If there is concern about the drugs administered or the function of any equipment involved in the case, then this should be stored securely whilst awaiting inspection. An accurate record should be made of all the checks undertaken including time and date of inspection. All disposable equipment including syringes and ampoules, airway devices etc. should be kept in a secure box. Further investigation may be required by medical equipment maintenance personnel, manufacturers or toxicologists.

If there is suspicion of equipment failure or a hazard affecting the theatre, a decision may be made to take the theatre or anaesthetic machine out of commission until appropriate investigation has taken place.

2.4 The media

Depending on the circumstances surrounding the death there may be media interest in the case. Staff should not make any comment to the media, and all enquiries should be directed to the Trust's communications team.

3.0 Later actions

The circumstances surrounding the death will be investigated by the Trust. This will be through the Trust M&M process/ Trust SUI inquiry/post-mortem report. The lessons learnt from the case will be shared with all relevant staff, via clinical governance processes/newsletter. Trust governance team to inform MHRA or NPSA if relevant.

Appropriate on-going emotional support (individual or group counselling) should be offered to staff. Details of some of the resources available are on the Trust extranet [here](#). A senior and experienced colleague should be assigned to act as a mentor and to provide emotional support for as long as is required. For non-consultant staff this would usually be provided by the educational supervisor.

Medical staff involved in a death should inform their medical defence organisation. They should reflect on the case as part of the appraisal process.

References

1. Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2005) Catastrophes in anaesthetic practice: dealing with the aftermath. Available at: [Catastrophes in anaesthetic practice](<https://anaesthetists.org/Home/Resources-publications/Guidelines/Catastrophes-in-Anaesthetic-Practice>)
2. Association of Anaesthetists Catastrophe Handbook (2025). Available at <https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Catastrophe%20Handbook%202026.pdf?ver=sGKEIDZH1l3sa7-QwVOXqg%3d%3d>

Full version control record

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This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

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2.0	Nov 2022	Consultant Anaesthetist	Final	
3.0	June 2026	Dr Thomas Heinink (Consultant Anaesthetist) Dr Kenneth O'Connor (Consultant Anaesthetist)	Final	Anaesthesia and Theatre Clinical Governance Committee meeting 20th May 2026

Related Documents

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