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Freuchen Medical Centre Policy: Disclosure of Medical Records after a Patient's Death

Policy Number: FMC-IG-25
Date Approved: 05 September 2025
Version: 1.0
Next Review: 04 September 2026

1. Purpose and Scope

This policy outlines the procedure for handling requests for access to the medical records of a deceased patient. It applies to all staff at Freuchen Medical Centre and is designed to ensure that such requests are handled sensitively, lawfully, and in accordance with the Access to Health Records Act (1990) and professional guidance from the General Medical Council (GMC).

This policy covers requests from family members, friends, partners, solicitors, or other individuals. It does not cover requests from statutory bodies like the police or coroner, which have different legal bases.

2. Guiding Principles

***Confidentiality*:** A duty of confidentiality to the patient continues after their death.
***Sensitivity*:** Requests must be handled with compassion and empathy.
***Lawfulness*:** Disclosure is strictly governed by the Access to Health Records Act (1990).
***Transparency*:** The process for requestors will be clear and communicated effectively.
***Security*:** Records will be handled and disclosed securely to protect personal information.

3. Legal Framework

The Data Protection Act (2018) and GDPR do not apply to deceased individuals. The key legislation is the Access to Health Records Act (1990) (AHRA).

3.1. Who can apply for access?

Under the AHRA, only the following individuals have a right to apply for access:
a) The patient's personal representative (this is the executor of the will or the administrator of the estate if there is no will).
b) Any person who may have a claim arising out of the patient's death (e.g., a potential clinical negligence claim, a life insurance claim, or a claim relating to a disputed will).

*Note: The term "Next of Kin" does not, in itself, confer a right of access unless that person also qualifies under one of the two categories above.

3.2. What information can be disclosed?

Access is only to be given to information **relevant** to the claim or the administration of the estate.
Access must **not** be given to any part of the record which:
Would disclose information likely to cause serious harm to the physical or mental health of any individual.

Would disclose information relating to an identifiable third party (other than a healthcare professional involved in the patient's care).
Any known wishes of the patient expressed in life regarding confidentiality must be respected.

4. Roles and Responsibilities

Practice Manager: Overall responsibility for the implementation of this policy. Acts as the primary point of contact for complex requests and liaison with PCSE.
GP Partners: Responsible for making the final decision on the application of exemptions (e.g., serious harm, third-party information) and authorising disclosure.
Administrative Staff: Responsible for acknowledging requests, managing correspondence, verifying documentation, and processing redacted records under the direction of a GP.

5. Procedure for Handling a Request

Step 1: Receipt and Acknowledgment

Upon receiving a request (verbal or written), provide the requester with a copy of this policy and a dedicated application form to capture necessary information.
Acknowledge the request in writing, offering condolences, and clearly outlining the next steps and the legal requirements.

Step 2: Verification of Right of Access

The requester must provide:
Proof of their identity.
A copy of the death certificate.
If applying as a personal representative: Evidence of their appointment (e.g., Grant of Probate, Letters of Administration, or the Will naming them as executor).
If applying due to a claim: A written statement explaining the nature of the claim arising from the death (e.g., from a solicitor or insurance company).

Step 3: Clarification of the Request

Clarify the exact information being sought (e.g., records relating to a specific condition, a specific time period, or the full record). This is essential to determine what is "relevant".

Step 4: Retrieval and Review of Records

Retrieve the deceased patient's record from the clinical system archive.
A designated GP must review the entire record to:
Identify information relevant to the request.
Redact information that is exempt from disclosure (third-party information, information likely to cause serious harm).
Respect any known prior wishes of the patient.

Step 5: Decision and Disclosure

Once reviewed and redacted, the relevant information can be disclosed.
Methods of disclosure can include: a summary letter, copies of specific parts of the record, or a meeting to discuss the findings, whichever is most appropriate and agreed upon.
Disclosure must be made within the statutory timeframe:
40 days if the record contains information made before the last 40 days.
21 days if the record only contains information made in the 40 days preceding the request.
No fee can be charged for providing access.

Step 6: Documentation

Full details of the request, verification documents received, the review process, and what was disclosed must be documented in the patient's record.

6. Requests Not Covered by the AHRA

If a person (e.g., a relative with no claim) does not qualify under the AHRA, they have no legal right to access. However, following GMC guidance, a GP may choose to disclose information if:
The patient would not have objected.
The disclosure is unlikely to cause distress to the family.
It will be of benefit to the bereaved person(s).
It does not contain confidential third-party information.
This is a professional discretion, not an obligation, and must be decided on a case-by-case basis.

7. Role of Primary Care Support England (PCSE)

Freuchen Medical Centre is responsible for responding to requests for records we hold. PCSE will only handle requests if:
The patient was unregistered at the time of death, or
The last registered GP practice has closed.
If part of the requested record is a paper record held by PCSE, we will provide the electronic portion we hold and direct the requester to PCSE for the remainder.

8. Clinical Negligence Claims

If a request indicates a potential clinical negligence claim, staff must immediately inform the Practice Manager. The Manager will notify:
The relevant Medical Defence Organisation (for events before 1 April 2019).
NHS Resolution's Clinical Negligence Scheme for General Practice (CNSGP) via cnsgpnotification@resolution.nhs.uk or their 24-hour helpline: 0800 0306798 (for events on or after 1 April 2019).

9. Retention

The deceased patient's electronic record must be retained on the practice system for a minimum of 10 years from the date of death, in accordance with the NHS Records Management Code of Practice.

10. Policy Review

This policy will be reviewed annually, or sooner in the event of significant changes in legislation or guidance.