Nottinghamshire Hospice
adding life to days

POLICY/PROCEDURE INFORMATION (Policy no CS012)	
Subject	**Verification of Death Policy** *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All clinical staff employed by Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	20 June 2023
Next review date	20 June 2026
Lead responsible for Policy	Director of Care
Policy reviewed by	Palliative Care Lead
Notified to (when)	Quality and Safety Committee 20 June 2023
Authorised by (when)	Quality and Safety Committee 20 June 2023
CQC Standard if applicable	
Links to other Hospice Policies	Equality and Diversity Policy HR00021 Infection Prevention and Control policy CS001 Mental Capacity Policy CS003 Reporting of Incidents and Accidents Policy OP002 Resuscitation & DNACPR Policy CS002 Risk Assessment Policy OP004 Clinical Supervision Policy and Procedure CS011
Links to external policies	Citycare Verification of Death by Registered Nurses Policy and Procedure Version 4 June 2019 Nottinghamshire Healthcare Verification of Death Procedure May 2019
Summary	This document sets out Nottinghamshire Hospice's policy and procedure on the Verification of death.
This policy replaces	Verification of Death Policy CS012 May 2020-2023

IMPORTANT NOTICE

Staff should refer to the Hospice website or Policies and Procedures folder on the 'N' drive for the most up to date Policy. If the review date of this document has expired it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by Liz Morgan, Clinical Nurse Specialist	March 2020	
Policy reviewed by Wendy Shelvey, Hospice in your Home Manager	May 2020	June 2023
Notified to Quality and Safety Committee	June 2020	
Policy ratified by Quality and Safety Committee	June 2020	
Reviewed by Palliative Care Lead	May 2023	
Notified to Quality and Safety Committee	20 June 2023	
Ratified by Quality and Safety Committee	20 June 2023	20 June 2026
Updated control sheet and published on website	October 2023	

1.	**Introduction** This document sets out Nottinghamshire Hospice's policy on the verification of death (VoD). It aims to: ● Ensure safe, legal and effective practice for verification of death ● Maintain patient safety ● Ensure that those who undertake verification of death understand the criteria of patients they can verify as deceased. ● Comply with national standards ● Enhance patient care and prevent delays in the verification of death, particularly out of normal working hours. ● Protect the wellbeing of hospice staff The act of verifying death is a process that allows clinicians to confirm the death of the patient within the community setting. This refers to adults over the age of 18, who meet the inclusion criteria in section 8. This process of verifying or confirming death is not to be confused with the act of certifying death. The law states that certifying death must be carried out by a registered medical practitioner.
2.	**Scope** This policy applies to all Registered Nurses including bank staff at Nottinghamshire Hospice, if verification of death is within their scope of practice. All Registered Nurses are personally accountable for their own practice. It is the overall responsibility of the Director of Care to ensure that this policy is implemented. To comply with the Nursing and Midwifery Council (NMC 2008) guidelines, NICE guidelines statement 13 (2017) and NCPC (2017), Nottinghamshire Hospice would expect all registered nurses to be able to verify the death of patients who fulfil the inclusion criteria. (Section 8) This policy applies to adults over 18 years of age.

3.	**Legislation** The law requires a doctor to notify the cause of death of any patient whom he or she has attended during that patient's last illness to the Registrar of Births and Deaths. The doctor is required to notify the cause of death as a certificate, on a form prescribed, stating to the best of his or her knowledge and belief, the cause of death. It should be noted that the strict interpretation of the law is that the doctor shall notify the cause of death, not the fact. Thus, a doctor does not certify that death has occurred, only what in his or her opinion was the cause, assuming that death has taken place. **English Law** ▪ *does* require the doctor who attended the deceased in the last illness to issue a certificate detailing the cause of death. ▪ *does not* require a doctor to confirm death has occurred or that life is extinct. ▪ *does not* require a doctor to view the body of a deceased person. ▪ *does not* require a doctor to report the fact the death has occurred. (British Medical Association, 2016). **Nurses** ● When a patient dies, the nurse has a duty to inform the doctor who has been treating the patient as the doctor is the only person authorised to certify the death (RCN 2016). ● It is the right of the verifying nurse to refuse to verify death and to request the attendance of the responsible doctor / police if there is any unusual situation. ● In the event of an unexpected death, the nurse has the responsibility to initiate resuscitative measures, unless a valid ReSPECT or DNACPR form is in place. (Resuscitation & DNACPR Policy CS002)

4.	**Definitions** **Death** Death is where there are no physical signs of life in a person and/ or there are signs of irrefutable death. It is the total and permanent cessation of all the vital functions of an organism**.** **Verification or Confirmation of death** Is the procedure of determining whether a patient is actually deceased. All deaths should be confirmed by following the identified **procedure in Section 11.** The process of confirmation can be performed by either a medical practitioner or other suitably qualified professional who has received confirmation of death training. **Certification of Death** The process of completing the Medical Certificate of Cause of Death **can only be carried out by a medical practitioner** according to rules defined by The Births and Death Registration Act 1953. Guidance for doctors completing medical certificates of cause of death in England and Wales (accessible version) - GOV.UK (www.gov.uk) **Expected death** An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. **Unexpected death** Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected there is a requirement to begin resuscitation, unless the patient has a do not attempt resuscitation or Advance Decision to Refuse Treatment (ADRT) form refusing cardiopulmonary resuscitation.

5.	**Legal Liability** Nottinghamshire Hospice will generally assume vicarious liability for the acts of its staff, including bank and agency staff. However, it is incumbent on staff to ensure that they: • have undergone any appropriate training and assessment of competence identified as necessary under the terms of this policy or their professional body • have been fully authorised by their line manager to undertake the activity • fully comply with the terms of any relevant Hospice policies and/or procedures at all times • only depart from any relevant Hospice guidelines when such a departure in the judgment of the responsible clinician is fully appropriate and justifiable; such decision to be fully recorded in the patient's notes
6.	**Responsibilities** **Board of Trustees** Trustees are responsible for ensuring adequate resources are made available to facilitate effective verification of death. **Quality and Safety Committee (Trustee led)** On behalf of the Board of Trustee this group is tasked with: • Ensuring any issues relating to verification of death have been handled effectively and are appropriately monitored. • Reporting back to the Trustee board The terms of reference for this group are agreed with the Trustee Board. **Chief Executive Officer** Has overall statutory responsibility for the safe and legal process around verification of death and has devolved the day-to-day management of this to the Director of Care.

	Director of Care Has the responsibility for ensuring • ensuring the hospice has the necessary clinical policies and procedures in place for safe and legal verification of death • ensuring that all appropriate registered nurses have access to this policy and any relevant updates. • ensuring that all appropriate registered nurses have attended the appropriate training • support is provided to staff following verification of death in the form of debrief/restorative supervision/counselling. **Registered Nurses** Registered Nurses (RN) are required to follow the NMC Code (2018) The standards provide specific guidance and state that as a registrant, nurses should always exercise their professional accountability in the best interests of their patients. This includes: • are aware of their clinical responsibilities regarding verification of death • have accessed the training programme in order to have understanding of their role and responsibility for verification of death • understand their role in explanation of verification of death to carers/family prior to death when undertaking verification of death and offer appropriate support • attend clinical supervision provided by Nottinghamshire Hospice as detailed in the Clinical Supervision Policy and Procedure CS011.
7.	**Risk Management** Risk assessment should be carried out in accordance with the Risk Assessment Policy (OP004) to determine the potential risks to patients and staff. All nurses verifying death should also attend annual Basic Life Support Training (with Automated External Defibrillator awareness) with updates as per Nottinghamshire Hospice minimum training matrix. Resuscitation must be attempted in all cases of cardiac arrest, whenever there is a

	chance of survival. The exceptions to this are: • If a valid ReSPECT or DNACPR decision has been made and the form completed, as per Resuscitation & DNACPR Policy CS002 • If an Advance Decision to Refuse Treatment regarding Cardiopulmonary Resuscitation is in place and made in line with the statutory requirements of the Mental Capacity Act (2005a). Mental Capacity Policy CS003. • Patients with features of irreversible death for example, Hypostasis (also known as postmortem staining) or Rigor Mortis, or a patient for whom there is no realistic prospect of a successful outcome (i.e. CPR would not re-start the heart and breathing for a sustained period). All nurses should be aware of the ethical/legal issues and accountability related to the act of verifying death. All infection control precautions should be followed as per current Infection Prevention and Control policy CS001. Following a death, the nurse should inform the funeral director if the patient has a known infection and complete the *Notification of Known Infection Transfer to Funeral Director form* **(Appendix 4).** **Appendix 1** shows a table of key infections that may be encountered. The Director of Care must review information on any verification of death errors and the Quality and Safety Committee meetings, will review trends and analysis and discuss any concerns regarding medication errors.
8.	**Inclusion and Exclusion Criteria** Registered Nurses can verify expected deaths that fulfil the following criteria: • A valid Do Not Attempt Cardio-Pulmonary Resuscitation order or ReSPECT in place. • Patients are known to have a palliative diagnosis and/or be on the Gold Standards Framework register and registered with EPaCCS. This includes when the person has died expectedly from or with COVID-19

	• The death can be verified if the doctor has seen the patient in the previous 28 days (1). This can be via a video link but not solely over the telephone. Confirmed or suspected COVID-19 does not by itself make the death sudden or unexpected; but could if the death was considered unexpected. • The GP has documented or given a verbal order that a registered nurse can verify the death. If verbal order received, this should be documented on SystmOne. • If the GP has not documented or given a verbal order that a registered nurse can verify the death, then the registered nurse should contact the GP or NEMS (OOH GP service) and they will authorise the VOD by the registered nurse. This should be documented on SystmOne. Registered Nurses cannot verify death in the following circumstances: • If the patient has not been seen or reviewed by the GP in the last 28 days • Unexpected, suspicious, or sudden deaths • Death of a person under 18 years old • Deaths of unidentified persons • Death of a person who has had surgery within the last 28 days • Deaths within 24 hours of illness or where no firm diagnosis has been made • Deaths following an untoward incident, fall, drug error or recent accident • The possibility of industrial disease or occupational disease e.g. mesothelioma Where the death is unexpected the police need to be involved. Referral to the Coroner's office MUST be made in the examples of circumstances in Section 9. A guide for referrals to coroner's office is attached at **Appendix 2.**
9.	**Unexpected Deaths** It is unlikely that Nottinghamshire Hospice would be providing care to someone not expected to die but it is still important to consider. **Indications that death was not expected:** • No documentary evidence that the person has a palliative diagnosis and is nearing the end of life • No evidence of an End-of-Life Advance Care Plan. • Patient does not have a completed EPaCCS template.

- Patient is not on the GSF register held in the patient's medical practice.

Note DNACPR OR ReSPECT form is not evidence that death is expected /not expected

- For any unexpected deaths, in the first instance, the police must be informed and your line manager/manager on call.
- The first person attending must preserve the scene and leave the body undisturbed until the police arrive.
- In hours, the patient's own GP must be contacted. Out of hours, contact GP on call.

If a person's death is not anticipated at that time but at the there is enough evidence from their clinical records and their family or carers to allow confidence that in retrospect it should have been expected, as long as there are no suspicious circumstances, a GP, nurse or paramedic should verify death and the GP should report the death to the coroner for assessment and discussion about the Medical Certificate of Cause of Death. Where the death is completely unexpected, the GP or a paramedic should verify death and the police must be informed and asked to assess. The body should not be moved until they have done so.

- The Coroner or Medical Examiner expects suspicious and unexpected deaths to be reported to the Coroner/Medical Examiner's Office. The Coroner or Medical Examiner's Office will then advise who can verify the death. If the Coroner or Medical Examiner's Office confirms that the nurse can verify death the nurse may verify death.
- Police will determine whether or not a funeral director can be called to remove the body or whether the body needs to be transported to the QMC mortuary.

As with all incidents, in the case of unexpected death, an incident form must be completed and recorded on the system as per the Nottinghamshire Hospice Reporting of Reporting of Incidents and Accidents Policy OP002.

Where the death is unexpected or notified to the police a notification to the Care Quality Commission within 24 hours will be made.

10.	**Equipment List** To maintain the safety of the Registered Nurse carrying out the verification of death, this procedure should be used in conjunction with local policy and applied to all verifications of expected adult death irrespective of any COVID-19 status (i.e. not suspected, suspected, confirmed), by donning surgical mask, gloves, eye protection and apron as a minimum when carrying out the verification of death procedure. **Stethoscope:** this is to be used to verify that there are no heart sounds. **Pen Torch:** this is used to ensure that pupils are fixed and dilated. **Two copies of the Verification of Death Performa** (**Appendix 3**) **Alcohol hand gel:** for Infection Prevention and Control.

11. PROCEDURE INCLUDING DOCUMENTATION

Expected Deaths

ACTIONS/PRINCIPLES OF CARE	RATIONALE/RESPONSIBILITY
Ensure that the patient meets the inclusion criteria for verification of death, and that none of the exclusion criteria are indicated. Check that there are no specific instructions from the family or patient's GP, requesting that nurses are not to complete the action of verifying death.	To ensure that patients/carers wishes are followed to reduce issues complicating the grieving process to ensure that there are no extenuating circumstances that would prevent the verification being undertaken by a registered nurse.
It is best practice to ensure that the registered medical practitioner has documented or given a verbal order that a registered nurse can verify the death.	To ensure practice is in line with current national guidance (NCPC 2017).
Confirm the identity of the patient by asking persons present and using patient's notes/SystmOne/EPaCCS.	To ensure the patient's identity corresponds with the patient's records being used for the process of verification.
Before commencing verifying the death complete a visual assessment of the environment and patient to ensure that there are no suspicious circumstances. Ensure it is safe to proceed. Check stock levels of medications against records e.g. injectable medicines-controlled drugs and report any discrepancies as per Nottinghamshire Hospice Reporting of Incidents and Accidents Policy OP002	If there are any suspicions, then the police must be contacted immediately. They will make an urgent referral to the coroner/medical examiner. The police will organise this when they are contacted. The environment must be preserved if there are any concerns until the police/coroner or medical examiner arrive. Ensure family are aware of this situation.
Appropriate PPE should be worn when verifying death. If the patient has a known infection then appropriate infection control precautions must be taken.	To adhere to the Notification of Infection Protocol. (**Appendix 1**)
Intravenous lines and similar systems e.g. portacaths and central lines must not be removed.	To adhere to national guidelines.
If there are no concerns about the indwelling urinary catheter (i.e. no catheter acquired infection), it can be removed. If there are any concerns or doubts, the catheter must be spigotted and remain in situ. Ensure the GP is	To adhere to local and national guidelines.

aware of this so a referral can be made to the coroner. Remove subcutaneous lines and complete form. (**Appendix 5**)	
Consider all cultural and religious beliefs and the patient's wishes and follow any specific requirements.	To ensure all patients are treated in accordance with the Equality and Diversity Policy HR00021.
Begin the five-point clinical findings checklist using the proforma as a template.	To confirm the physical aspects of life are extinct.
Observe for the absence of chest and abdominal movements for one minute.	To confirm the absence of signs of spontaneous respiration.
Using a stethoscope listen for heart sounds for one minute.	To confirm the heart has ceased to function.
Palpate the carotid artery for signs of a pulse for one minute.	To confirm circulatory collapse.
Check that each pupil is fixed and dilated using a pen torch or equivalent light source.	To confirm cerebral function has ceased.
Check for reaction to painful stimuli, either trapezium squeeze or ear lobe pinch.	To confirm there is no response to sensory stimulus.
If all of the clinical signs are absent then this can be recorded as the time that death was verified.	Time of death can only be recorded at this time as this is the earliest time that life has been confirmed as extinct.
After 10 minutes the five clinical signs must be rechecked to ensure that life is extinct.	To ensure that all clinical signs of life are extinct.
Complete the Verification of death Proforma.	To comply with Local and National Record-Keeping guidance.
If the patient has a known infection the funeral directors must be informed. Complete the Notification of Known Infection Transfer to Funeral Director form **(Appendix 4)**	To ensure appropriate Infection control precautions are being maintained by all those who come in contact with the deceased.
Leave a copy of the completed Verification of Death proforma for the funeral director and the second copy to be given to Nottinghamshire Hospice care coordinators for filing.	To ensure prompt and effective communication, which is key at this time.
During daytime hours inform patients own GP and community nursing team of death as soon as is practicable. Out of Hours contact Out of Hours provider	To ensure that the patient's own GP is aware of the death as soon as possible.

and nursing team stating patient has deceased. A call will be generated to the patient's own GP.	
A death where postmortem or other procedure is indicated then mark on the proforma to refer to the coroner and explain to the family/carer what this entails.	This is important for family/carers to understand what actions will be taken if necessary.
Ensure the deceased is left in a dignified and appropriate manner.	To ensure that deceased person is left in an appropriate manner for funeral directors to collect.
Discuss with the family regarding telephoning the funeral directors and if appropriate the nurse can do this. Inform funeral directors if referral to Coroner is necessary.	Contacting the funeral directors (as appropriate) can assist family/carer at this stressful time.
Provide information either verbal or written to relative/carer regarding what they have to do next, registering the death, arranging the funeral etc.	To ensure the relatives have an understanding of what they need to do regarding organising the funeral and other matters.
Leave nursing notes and medicines in the house to be disposed of according to Community Nursing Teams policy	To ensure that records are kept for future reference if required. To ensure safe disposal of drugs.
Handover to care coordinators at Nottinghamshire Hospice updating them of clinical details and own whereabouts and safety.	To ensure communication with the wider MDT and to maintain staff safety

A medical practitioner will then certify death. The family member or carer who takes responsibility for funeral arrangements etc. needs to understand their role when registering the death; this must be completed within 5 working days of the death certificate being written as determined by the Births and Deaths Registration Act (1953). If death referred to the coroner a medical certificate will be issued once the body has been released from the coroner.

For the family to register the death an appointment must be made with the registry office, who will inform further procedure necessary to register the death. The family will require the death certificate prior to booking the appointment.

12. Removal of Equipment

Expected Death

- In the case of an expected death subcutaneous lines and syringe pumps should be disconnected and removed (**Appendix 5**)
- If there are no concerns about the indwelling urinary catheter (i.e. no catheter acquired infection), it can be removed. If there are any concerns or doubts, the catheter must be spigotted and remain in. Ensure the GP is aware of this so a referral can be made to the coroner. Intravenous lines and similar systems e.g. portacaths and central lines must not be removed

Unexpected deaths

If a patient dies and the death is reportable to the Coroner or Medical Examiner, you should leave all equipment in place until you have discussed the case with the Coroner's Officer.

Equipment such as intravenous lines, drains, catheters etc. should be left undisturbed. This is to preserve any forensic evidence, and to give the coroner's pathologist the best opportunity for independent inspection and assessment of the case. The equipment may be relevant not only in cases of possible crime, but also in cases where clinical management may be called into question.

Examples of items that should be left undisturbed include:

- Endotracheal tubes
- Intravascular lines
- Drains
- Cannulas
- Catheters
- Feeding tubes
- Defibrillator pads
- Cardiac pacing devices
- Sutures.

13.	**Education and Training** All Registered Nurses are personally accountable for their own practice and therefore need to ensure they are competent in accordance with the NMC standards and the Hospice Code of Conduct. In order for a Registered Nurse to verify an expected death in a safe and competent manner they must have: ● Minimum of 6 months post registration experience and the confidence to undertake the procedure ● Attended mandatory Resuscitation Training ● Be able to determine the physiological aspects of death. ● Be aware of the legal issues and related accountability which relates to this extended scope of professional practice. ● Attended appropriate recognised training. Staff will attend the verification of death training provided by Nottinghamshire CityCare Partnership, based on national guidance and includes the following: ○ Roles and responsibilities in verifying death ○ Discussing challenging issues regarding verifying death ○ Protocols and procedure when verifying death ○ Unexpected deaths ○ Deaths reportable to the coroner ○ Support and aftercare for the family and significant others following death Upon completion of training, a certificate of attendance will be issued along with a Self-Assessment Competency Statement. This provides evidence that must be kept as part of the individual's training and competency record.
14.	**Equality Impact Assessment** A full Equality Impact Assessment was completed.

15.	**References**

1. Care After Death: Registered Nurse Verification of Expected Adult Death guidance | Hospice UK
2. Births and Deaths Registration Act 1953. Chapter 20 1_and_2_Eliz_2. London: HMSO. Available at: http://www.legislation.gov.uk/ukpga/Eliz2/1-2/20/enacted
3. British Medical Association (2016) Confirmation and certification of death: Guidance for GPs in England and Wales. Guidance for GPs in England and Wales. London: BMA
4. Health and Safety Executive (2018) Controlling the risks of infection at work from human remains. Appendix 1. Key infections.
5. National Council for Palliative Care (NCPC) (2017) Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance.
6. NICE (2017) Care of Dying Adults in the Last Days of Life. DOH: London.
7. Nottingham CityCare Partnerships Verification of Death by Registered Nurses Policy and Procedure Version 4 2019.
8. Nursing and Midwifery Council (2008) Nurses and Midwifes: Advise. Confirmation of death for registered nurses. Available at: http://www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Confirmation-of-death-for-registered-nurses/
9. Nursing and Midwifery Council (2018) The Code Guidance on Professional Standards of Practice and Behaviour for Nurses and Midwives
10. Mental Capacity Act. (2005a) London: Crown Copyright. http://www.legislation.gov.uk/ukpga/2005/9/contents
11. Royal College of Nursing. (2016). Confirmation of verification of death by registered nurses. Available at: https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death
12. Special Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance https://www.rcn.org.uk/.../special-edition-of-care-after-death.pdf?la=en

Controlling The Risks of Infection

Verification of Death by Registered Nurses Policy and Procedure June 2019 Nottingham CityCare

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can post-mortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Airborne Small particles that can remain airborne with potential for transmission by inhalation							
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes[2]	Yes[3]	Yes	Yes[3]
Middle East respiratory syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Severe acute respiratory syndromes (SARS)	eg SARS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Droplet Large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose or eyes)							
Meningococcal septicaemia (meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes[5]	Yes	Yes[5]
Flu (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes[5]	Yes	Yes[5]
Diphtheria	*Corynebacterium diptheriae*	2	No	Yes	Yes	Yes	Yes
Contact Either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes[5]	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	No[6]	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No[6]	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No[6]	Yes	Yes	Yes	Yes
Enteric fever (typhoid/ paratyphoid)	*Salmonella typhi/ paratyphi*	3	No[6]	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis*	3	No	Yes	Yes[4]	Yes	Yes[4]
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxin-producing *E.coli* (eg O157: H7)	3	No[6]	Yes	Yes[4]	Yes	Yes[4]

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can post-mortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Contact Either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired immune deficiency syndrome (AIDS)-related illness	Human immunodeficiency virus	3	No	Yes	Yes[7]	Yes	Yes[7]
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[8]	No	No
Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes[7]	Yes	Yes[7]
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	Specifically Lassa fever, Ebola, Marburg, Crimean-Congo haemorrhagic fever viruses	4	Yes[9]	No	No	No	No
Contact Either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							
Transmissible spongiform encephalopathies (eg CJD)	Various prions	3	Yes	Yes	Yes[10]	Yes	No

Key

Red Minimise procedures or handling of the deceased

Yellow TBPs are necessary when carrying out procedures or handling the deceased

The highlighted areas indicate an increased level of risk associated with the infection to workers (with areas in red posing increased risk) and therefore require additional control measures when handling the deceased.

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is, or is likely to be, leakage of body fluids.

[2] With appropriate measures to deal with potential release of aerosols (eg place cloth or mask over mouth when moving the deceased).

[3] With appropriate measures to deal with aerosol-generating procedures.

[4] With measures to minimise environmental contamination (because of low infectious dose; ie the amount of pathogen or number of bacteria required to cause an infection is low).

[5] With appropriate measures to prevent exposure of mucosal surfaces (eg a physical barrier to protect eyes, mouth and nose, such as a facemask or visor).

[6] Although illness may have increased likelihood of leakage of body fluids.

[7] With appropriate robust measures for the use of sharps (eg minimise use or use safer sharps devices).

[8] Before undertaking a procedure, the rationale for a post-mortem should be carefully considered where anthrax infection is suspected, particularly where examination may increase the potential for aerosol generation.

[9] With double body bag.

[10] With appropriate measures to minimise percutaneous injury and contamination of work area, and to help with decontamination (eg high-level sharps control or dedicated equipment).

Deaths That Should be Referred to the Coroner or Medical Examiner

1. The cause of death is not known.
2. Cause of death may be due to trauma or unnatural cause e.g. road traffic collision, possible suicide, poisoning, self-harm, fracture.
3. Cause of death may be related to an industrial disease e.g. pneumoconiosis, (deceased was a miner), mesothelioma, farmer's lung.
4. The patient had been in hospital for less than 24 hours.
5. Cause of death is due to a fall or there has been a fall in the three days prior to death.
6. At death, grade 3 or 4 pressure sore present, or more than one grade 2 pressure sore.
7. Surgery or invasive procedure involving general or local anaesthetic performed within the preceding 12 months (including endoscopies).
8. If the death is expected and there are no concerns over the catheter (i.e. no catheter acquired infections) it can be removed. Any concerns or doubts – leave catheter in situ and ensure the GP is aware of this so a referral to the coroner can be made.
9. A medical procedure or treatment which may have caused or contributed to the death. For the avoidance of doubt, a medical procedure includes chemotherapy, radiotherapy, biological/hormonal therapies, stem cell and bone marrow transplants.
10. Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate.
11. Death during pregnancy or within a year of giving birth.
12. All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. deaths of all minors under the age of 18 years. It is very important that all doctors are conversant with the "signs of life" protocols and guidelines for neonatal cases - if further guidance is required on this please consult with the Trust and/or our office. We have had cases in this category where child deaths have not been reported to HMC but were picked up by the Registrar and then referred to HMC, causing great distress to the families.
13. Death is associated with or occurs after a clinical incident.
14. Where allegations of negligence have been made against the hospital or others involved in the nursing or medical care of the deceased, regardless of whether it is considered such allegations have merit.
15. Death may be due to the neglect of others.
16. Any other unusual circumstances.

If there is any doubt about whether a Coroner's referral is required, the first point of contact should be the Consultant or GP in charge of the care. The Consultant or GP has the ultimate responsibility for decisions on referral. In General Practice, it is a good idea to discuss the case with a partner – if in doubt, refer to the Coroner. The referral should be made on the online form accepted by the coroners office, together with a proposal for the cause of death if the reporting doctor is happy to issue the MCCD. The coroner's office generally return feedback for these within 48h.

Dr J Barker (2019) Death Administration Guidance in the Community, Mid Notts EOL Lead

VERIFICATION OF AN EXPECTED DEATH BY REGISTERED NURSE

Surname:	**Location of Death (if different from home address)**
Forename (s):	**Address:**
Address:	
Postcode:	**Patients GP details: Name**
DOB:	**Address:**
Tel No:	**Tel No:**

Relative/Carer Name:	**Present at Death: Yes / No**
If no, then contacted by:	**Time contacted:**

VERIFICATION OF DEATH

1.	Absence of respiratory movements and breath sounds after observation and listening with stethoscope for one minute		
2.	Absence of a major arterial pulse, e.g.: Femoral, Carotid, Brachial after palpitation for at least one minute		
3.	Absence of heart sounds after listening with a stethoscope for at least one minute.		
4.	Both pupils are fixed, dilated and do not respond when light source is used, e.g.: pen torch.		
5.	No response to painful stimuli, determined		

Protheses: Please specify if known (i.e. internal defibrillator, pacemaker etc)

Life Verified extinct at : (24 hr Clock) **Date:**

Name of Nurse Verifying Death:	Contact Tel No**:**
Signature:	Print:
Name of GP informed:	
Date:	Time:
Funeral Directors:	Tel:
Other Professionals Contacted:	

Any other relevant information: -

Notification of Known Infection
Transfer to Funeral Director

Name of deceased ……

Date and time of death …….

The deceased's remains are a potential source of infection*:

Yes ☐ Unknown ☐

If yes please state the known infection

……

Name of clinician …….

Signature and Date …….

* Not all infected patients display typical symptoms; therefore some infections (including blood-borne viral infections) may not have been identified at the time of death.

Appendix 5

REMOVAL OF CONTINUOUS SUBCUTANEOUS INFUSION

Name of Patient:	
D.O.B:	
Address:	

In addition to verification of death, an infusion was removed From_____(indicate site)

Name of Drugs:	
Amount Remaining:	
Infusing at a rate of:	
Set Up (Date and Time)	

The infusion was calculated and confirmed as delivering correct amount. The contents of the syringe were then unusable.

Verifier:

Name: _____

Signature: _____

Date_____ **Time:** _____