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NHS
North Yorkshire and York
Community and Mental Health Services

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| Title: | **Policy for Verification of Death in the Community** |
| Reference No: | CMHS 072 |
| Owner: | Director of Operations |
| Author: | David Hogg, Resuscitation Officer |
| First Issued On: | February 2010 [v 0.001] |
| Latest Issue Date: | January 2011 [v1.000] |
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| Consultation Process: | Palliative Care Leads<br>Adult Governance Group |
| Policy Sponsor: | Resuscitation Committee |
| Ratified and Approved by: | CMHS Governance Committee |
| Distribution: | All staff |
| Compliance: | Mandatory for all permanent & temporary employees, contractors & sub-contractors of North Yorkshire and York PCT |
| Equality & Diversity Statement: | This policy has been subject to a full equality and diversity assessment |

Please note that the intranet version is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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| CHANGE RECORD | | | |
|---|---|---|---|
| **DATE** | **AUTHOR** | **NATURE OF CHANGE** | **VERSION No** |
| 02 2010 | D Hogg, Resusc Officer | First policy draft | 0.001 |
| 03 2010 to 09 2010 | | Amendments, comments Community Policy Group, Adult Governance Group, Palliative Care Leads | 0.002-0.006 |
| 25 01 2011 | | Ratified CMHS Governance | 1.000 |

## Preface

This Policy is made between North Yorkshire and York Primary Care Trust (NYY PCT; "the PCT") and the recognised staff side organisations, using the mechanism of the Joint Negotiation and Consultative Committee (JNCC) and Local Negotiating Committee (LNC). It will remain in force until superseded by a replacement Policy, or until terminated by either management or staff side, giving no less than six months notice. The purpose of the notice to terminate the Policy is to provide the opportunity for both parties to renegotiate a replacement Policy. Withdrawal by one party, giving no less than six months notice, will not of itself invalidate the agreement. If agreement cannot be reached on a revised policy, then the matter will be dealt with through the PCT's Grievance Procedure.

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## Section 1 Scope and Aims of the Policy

### 1.1 Scope:

The Policy is of primary interest to all clinical staff working in community teams and in-patient units within NHS North Yorkshire and York Primary Care Trust. The Policy will be implemented for use by Medical and First Level NMC Registered Nurses directly employed by NHS North Yorkshire and York PCT; for whom the Primary Care Trust has a legal responsibility.

### 1.2 Aims:

- Provide supportive clear guidelines relating to the professional, legal and training requirements for healthcare professionals who in the course of their duties will be required to verify death.
- Provide clear pathways to follow when the policy is implemented in clinical practice in situations of predicted / expected deaths or sudden / unexpected deaths.
- Respectful of the diversity of opinions that exists in the healthcare teams, the policy will ensure a consistent team approach when verifying death.
- Differentiate between Verification of Death and Certification of Death
- Raise awareness and identify conditions which are reportable to the Coroner and / or a post-mortem examination needs to be fulfilled. .
- Identify circumstances where a Registered Nurse is not authorised to verify death
- Ensure the death of a patient is dealt with in a professional timely manner, preventing unnecessary delays in removal of the deceased to an appropriate place, preventing additional stress for either relatives/carers, staff or other patients.
- Ensure the safety of patients is not compromised by provision of competently trained healthcare professionals.
- Ensure that the procedure undertaken following death does not compromise health and safety.
- Raise awareness of responsibilities and the requirement to protect potential forensic evidence in specific circumstances.
- Ensure the dignity and delivery of culturally appropriate care for the deceased and the bereaved is maintained after death.

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## Section 2 Legal Position

### 2.1 Medical Practitioners

The law requires that:
"A registered medical practitioner, who has attended a deceased person during his/her last illness, is required to give a medical certificate of the cause of death to the best of his knowledge and belief, and to deliver that certificate forthwith to the Registrar. The certificate requires that the doctor state the last date on which he saw the deceased person alive, whether or not he saw the body after death. He is not obliged to view the body, but good practice requires that if he is in any doubt about the fact of death, he should satisfy himself in this way".

***Para 5.01 Report of the Committee on the Death Certification and Coroners Home Office (1971)***

- While there is no statutory duty on doctors for reporting deaths to the coroner, however doctors have voluntarily assumed the primary responsibility for such reporting.

- However there are certain conditions/ circumstances that require to be reported to the coroner. These are outlined in Appendix A or details can be found in 'Consultation On Improving the Process of Death Certification **(Department of Health 2007).**

### 2.2 Registered Nurses

**Nursing and Midwifery Council (NMC) Advice Sheet : Confirmation of death – for Registered Nurses April 2008**:

A Registered Nurse cannot legally certify death – this is one of the few activities required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities e.g. the police or the coroner, should be informed prior to removal of the body.

A Registered Nurse undertaking this responsibility must:

- be aware of their accountability when performing this role
- only do so providing they have received appropriate education and training and have been assessed competent.
- recognise and work within the limits of their competence
- keep knowledge and skills up to date

(The Code NMC 2008)

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## Section 3 Terminology

### 3.1 Certification of Death

**3.1.1** Certification of death is the process of completing the 'Medical Certificate of Cause of Death'. Certification of death has to be carried out by a Registered Medical Practitioner as determined by part 11 of the Births and Deaths Registration Act 1953.

**3.1.2** In all cases the patient's GP should produce a Death / Medical certificate of the **cause** of death 'to the best of his knowledge and belief' within 24 hours of the patient's death.

**3.1.3** If the death occurred during the weekend or on a Bank Holiday, the certificate should be produced on the next working day.

**3.1.4** The doctor has to state the date he last saw the deceased and whether or not he saw the body after death

**3.1.5** The doctor is not obliged to view the body, but good practice requires if there is any doubt the doctor should see the body (Home Office 1971)

**3.1.6** A Registered Nurse cannot legally certify death.

### 3.2 Verification of Death

**3.2.1** Verification of Death can be defined as a healthcare professional clinically examining a patient and deciding whether the patient has actually deceased and life is extinct.

**3.2.2** Traditionally a registered medical practitioner was called upon to pronounce life extinct, however English law does not require a medical practitioner to confirm death has occurred

**3.2.3** To verify the fact of death the body must not have been moved to any setting in which survival would be compromised e.g. mortuary refrigerator.

**3.2.4** A First Level Registered Nurse with current U.K Nursing & Midwifery Registration, working in an area with an explicit local policy in place and having undertaken training and demonstrated the necessary competencies has the authority to verify death, notify relatives and arrange for removal of the body

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### 3.3 Expected /Predicted death (Appendix Bi)

**3.3.1** For the purpose of this Policy expected death can be defined when the patient's demise is imminent following on from a period of illness that has been identified as terminal and where active interventions to prolong life are deemed to be futile.

**3.3.2** A predictable death can be defined as the patient having been diagnosed with a condition which has been identified as terminal. Due to the nature of the condition death will be inevitable in the future may be days/weeks or months; the exact time may be difficult to predict.

**3.3.3** Doctors are responsible for identifying patients whose death is expected. Such identification will include the views of the patient (where possible), relatives/carers and the multi-disciplinary team

**3.3.4** The prognosis will have been discussed with patient (when possible) relatives/carers and the multi-disciplinary team and will be clearly documented either in the community in-patient / home care records within an Integrated Care Pathway for End of Life Care) or appropriate Out-of-Hours documentation. A DNAR order / Living Will / Advanced Decision or Advanced statement should be in place. (NYYPCT DNAR Policy 2009)

**3.3.5** Although an expected death the healthcare practitioner should satisfy themselves there were no unclear or suspicious circumstances just prior to death. In addition consideration should be made to check the ultimate cause of death does not require to be reported to the coroner e.g. asbestosis **(Appendix A – Reportable Deaths)**

**3.3.6** It is recognised that in some situations the death was considered to be predictable but may occur suddenly / unexpectedly.

**3.3.7** In the event of a predicted death occurring suddenly, it will be necessary for the healthcare practitioner to establish the events just prior to death and satisfy themselves there were no unclear or suspicious circumstances just prior to death. In addition consideration should be made to check the ultimate cause of death does not require to be reported to the coroner e.g. asbestosis **(Appendix A – Reportable Deaths)**

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### 3.4 Unexpected/Sudden (Appendix Bii)

**3.4.1** n the event of a patient dying suddenly from a predictable death, providing there is a DNAR order, advanced directive or living will in place and no unclear or suspicious circumstances all healthcare professionals may verify the death but inform the Coroners officer (via the police).

**3.4.2** If the patient is an in-patient and no advance decision has been made and there is no documentation about the appropriate or otherwise of attempting resuscitation, should they suffer a cardiac or respiratory arrest, basic life support should commence immediately (NYYPCT Resuscitation Policy 2010). In the event of an unsuccessful resuscitation the death is unexpected.

**3.4.3** If a patient dies suddenly whilst an in-patient in the community hospital and there is no DNAR in place, no diagnosis or clear documentation a medical practitioner must verify death and inform the coroner via the police. If there are any unclear / suspicious circumstances care must be taken to preserve forensic evidence.

**3.4.4** Healthcare professionals visiting the patient at home may be faced with very different situations regarding unexpected death to those experienced by staff working within the in-patient facilities. For example staff making a planned visit to a patient may find the patient has died hours or days before and obviously not appropriate for the initiation of resuscitation procedures.

**3.4.5** In the event of a healthcare professional finding one of their patients has deceased and the body shows **signs unequivocally associated with death,** Do not move the body, preserve forensic evidence.

**3.4.6** Conditions unequivocally associated with death in all age groups

- **Hypostasis**
- **Rigor mortis**
- **Decomposition**

**3.4.7** Verification of death must be done by a medical practitioner who will inform the coroner via the police, with care being taken to preserve scene forensic evidence.

**3.4.8** Alternatively the community nurses or OOH service may be contacted by relatives/carers to inform them that a death has occurred unexpectedly. The relatives /carers may or may not have been present at the time of the death they are reporting.

## Section 4 Role of the General Practitioner

**4.1** Visit the deceased to verify death if no other competent healthcare professional is available

**4.2** Verify death if the circumstances /conditions surrounding the death preclude a Registered Nurse from undertaking the process (Section 7)

**4.3** In support of good practice the GP should arrange to see the deceased as soon as practical. To prevent additional distress to the bereaved, the nursing staff and other patients this process need not delay the removal of the body to the chosen undertakers premises / mortuary.

**4.4** Consider the needs of living persons including relatives/carers of the deceased and other patient's in the clinical vicinity of the deceased.

**4.5** Where the deceased's own general practitioner is not available, another doctor should access whether a visit is needed to meet the needs of living patients (e.g. bereaved)

**4.6** Issue the Death / Medical Certificate for the cause of death

**Further Guidance can be found at Confirmation & Certification of Death: Guidance for GP's in England and Wales (1999)**

www.bma.ork.uk/health_promption_ethics/end_life_issues/GeneralguidanceConfirmationandcertificationOfDeath/April1999.jsp

## Section 5 Role of the Out-of-Hours Service or Deputy General Practitioner

**5.1** The deputy GP/OOH doctor will not be the certifying doctor and is unlikely to have any connection with the relatives or any access to the medical records.

**5.2** If a deputy GP or Out-of-Hours organisation is contacted about a death, either by the bereaved relative/carer, community nursing staff or Yorkshire Ambulance personnel, the doctor must make an assessment to decide whether a visit is appropriate. If a visit is deemed appropriate in support of good practice the doctor should see the deceased as soon as practical.

**5.3** A visit will be necessary when:

- There is no other health care professional available who is competent to verify death
- The circumstances preclude the nurse from undertaking the procedure
- There is uncertainty surrounding the facts/details of death.

- A request has been made by relatives or the nursing staff for a visit by a doctor to meet the needs of bereaved relatives/carers.

Although an assessment of the situation may not indicate a visit, the doctor may decide that a visit would be in the interests of the bereaved / carers and this should be arranged.

**Further Guidance can be found at Confirmation & Certification of Death: Guidance for GP's in England and Wales (1999)**

## Section 6 Role of the Registered Nurse

**6.1** Verification of Death is only to be undertaken by a First Level Registered Nurse with current NMC Registration who has undertaken appropriate verification of death training and has been assessed as being competent in the knowledge and skills required for safe and effective practice. **(NMC 2008)**.

**6.2** Verification of death can be carried out in the home, residential care setting or in the community hospital

**6.3** Ensure the relatives / carers understand and accept the verification of death will be undertaken by the nurse and not a doctor. Respect their wishes if they request the procedure to be carried out by a doctor.

**6.4** A Registered Nurse must not verify death in a person where there is no clear documentation, when any circumstance surrounding the death is unclear or suspicious, or if the cause of death is reportable to the Coroner (**Appendix A)**

**6.5** In the event of the circumstances of a death precluding a nurse from undertaking verification, the patients GP/ On call Locum or Out of Hours Doctor has the responsibility to verify death and refer to the coroner

**6.6** Verification of death must be done before last offices commence

**6.7**Last offices relates to the care given to a body after death and the nurse must ensure the process demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs. The wishes of the patient and the bereaved may influence practice, however the nurse must ensure care given and the verification of death process undertaken is compliant with legal guidelines and maintain a high regard for health and safety issues **(Higgins 2008)**.

**6.8** In some circumstances the relatives / carers may need support to contact significant others in order to arrange last offices or practice requested by the culture /

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religious beliefs of the deceased. (e.g elderly relative with no other close NoK they can approach for support)

**6.9** The nurse has responsibility to the deceased patient until the body leaves the clinical environment.

**6.10** Excellent documentation standards are required throughout the process

## Section 7 Procedure to follow (Expected Death)

- Notify relatives / carers if not present at time of death
- Ensure the correct identity of the patient is confirmed
- Explain the verification of death process to the relatives /carers
- Death must be verified **before** last offices commence

### 7.1 Examination of the deceased

- Ensure privacy for the procedure and inform other staff to ensure the verification process is free from interruptions
- Collect all equipment necessary before commencing the procedure
- No parenteral drug administration equipment or symptom relieving equipment should be removed prior to verification of death.
- Document the drug /dose/infusion rate of any drug and the amount left in the infusion. Leave all lines, tubes and access devices in situ. Any that remain should be closed or have spigot inserted, then covered with gauze and adhesive dressing
- Using a stethoscope listen for the absence of respiration sounds for one minute and observe for signs of chest movement.
- Using a stethoscope listen for the absence of heart sounds for one minute.
- Check patient's pupil reaction using an independent light source i.e. pen torch, ophthalmoscope, do not use room light only. The pupils will be fixed, dilated and not reacting to light.
- Check there is no response to painful stimuli.

### 7.2 Documentation

- The Verification of Death Record should be used in all situations **(Appendix C)** All records must be clearly written, clearly signed and the name printed after each entry Document the following:
    - A clear indication of the definitive diagnosis and why death was expected
    - Name and relationship of the person identifying the deceased.
    - Any persons present at the time of death
    - Circumstances of death e.g. place of death

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Date and exact time of death where possible. In cases reported by relatives, the time of death should be established as closely as possible.
    - Time of verification of death is made
    - Any internal devices left in situ e.g. pace maker, internal defibrillator
    - Identify location of tubes, lines and access devices left in situ.
    - Time the police / coroners officer was informed (if applicable) and note the name /number of any police officer attending
    - Where the body was removed to.
    - Any other important or relevant detail for individual circumstances
- Document in the patients clinical notes / home nursing record:
    - Verification of Death Record was completed,
    - Which NoK / carers informed if not present at the death and by whom
    - time and date of death and that death was verified indicating absence of respiratory, heart sounds and papillary reaction.
- The person verifying death should formally communicate to the deceased patients GP as soon as possible. **Appendix C** can be used as a written template at scene to inform the patients GP and/or the information can then be recorded on the Electronic Verification of Death Form and e-mailed to the GP, Out-of-Hours service and Lead Resuscitation Officer.

### 7.3 Health and Safety Issues

The body following death must be prepared for transfer to the mortuary or funeral directors in a way that does not compromise health and safety.

Reference should be made to relevant Infection, Prevention and Control Policies.

### 7.4 After verification of death has been made

- Support relatives/carers to arrange last offices or practice requested by the culture / religious beliefs of the deceased
- In the patient died whilst an inpatient provide a quiet area to allow the family to contact their chosen undertaker to collect the deceased or arrange for removal of the body to the hospital mortuary (depends on local arrangements).
- Remove the clinical record from patients home if applicable
- Ensure relatives/carers know what to do e.g. register the death, know who to contact.
- If the deceased is known to have an infection, ensure the shroud is labelled appropriately or the undertakers are informed. Good communication will be essential as the use of danger of infection labels may cause offence or concern.
- If the body has not been moved after verification of death for whatever reason by the time staff change over, the nurse who verified death should ensure full details are handed over to the senior nurse coming on duty and document who the care of the deceased and relatives was handed over to.

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## Section 8 Training Requirements

Training in the Verification of death should as a minimum cover the following:

- An understanding of the legal requirements for verifying death
- Distinguish difference between Certification of Death and Verification of Death
- Comprehension of the terms used and procedures to follow in the NYYPCT Verification of Death Policy
- Clarification and understanding of individual healthcare professionals roles
- Role of the Funeral Director
- Role of the Coroner / Police
- Documentation for Verification of Death
- Information to be given to the relatives/carers following bereavement
- Registered Nurses will receive the practical clinical skills necessary to verify death by an experienced clinician
- The individual will be responsible for maintaining their competency certification and providing it on request

## Section 9 Associated Policies & Documents

NHS North Yorkshire & York PCT (2010) Resuscitation **Policy** Re-ratified date: January 2010

NHS North Yorkshire & York PCT (2009) **Do Not Attempt Resuscitation Policy** Issue date: September 2009

Last Offices for patients with Infection **North Yorkshire Community Infection, Prevention and Control Policies (39 Policy & Guidance Notes)** November 2008

## Section 10 Monitoring Compliance and Effectiveness of Policy

The monitoring compliance and effectiveness of this policy will be monitored through the following processes and reported through the PCT Resuscitation Committee:

- Competency training records
- Audit of Verification of Death Records
- Quality and Outcomes Framework in General Practice
- Adverse Incident Reporting Procedure

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## Section 11 Reviewing, Approving and Archiving this Document

- This document will be reviewed as per the cover page, or when changes are required, whichever occurs first
- The review process will be undertaken primarily by the organisation-wide Resuscitation Committee
- Following review it will be subject to re-ratification by CMHS Governance Committee
- Archiving of this document should be conducted in accordance with the organisation's electronic archiving procedure.

## Section 12 Policy dissemination, Implementation

- The Policy will be implemented and disseminated throughout the organisation immediately following ratification
- The Policy document will be published on the Organisations intranet site.
- The Policy document will be open for all to access.
- Managers / Team Leaders will be responsible for distribution within the area of responsibility, keeping a record of distribution and implementation as appropriate.

## Section 13 References


**Confirmation and Certification of Death- Guidance for GP's in England & Wales** (1999) General Practitioner Committee, BMA, London

**Confirmation of Death** (2008) Nursing and Midwifery Council : London

**Department of Health (2007)** Consultation on Improving The Process of Death Certification : London

**DNAR Do Not Attempt Resuscitation Policy** (2009) NHS North Yorkshire & York PCT

**Dorries C.P.** (2004) Coroner's Courts : A guide to law and practice John Wiley & Sons : Chichester

**Higgins D (2008)** Carrying out Last Offices Part 1 – Preparing for the Procedure : Nursing Times V 104: no 37 September 2008 pp 20-21

**Report of the Committee on Death Certification and Coroners** (1971) Home Office, London

**Report of the Home Office Review of Death Certification, Executive Summary and Recommendations** (2001) Home Office : London

**Resuscitation Policy** (2010) NHS North Yorkshire & York PCT

**The Code : Standards of Conduct, Performance and Ethics for Nurse and Midwives** (2008) Nursing and Midwifery Council : London

www.bma.ork.uk/health promption ethics/end life issues/GeneralguidanceConfirmationandcertificationOfDeath/April1999.jsp

**Appendix A Deaths that must be reported to the coroner**

- The person is unidentified
- The cause of death is unknown
- The death of a child
- It cannot readily be certified as being due to natural causes
- The deceased was not attended by a doctor during his last illness or was not seen within the last 14 days or viewed after death
- There are any suspicious circumstances or history of violence
- The death may be linked to an accident (whenever it occurred)
- If there is any question of self neglect or neglect by others
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station)
- The deceased was detained under the Mental Health Act
- The death is linked to an abortion
- The death might have been contributed to by the actions of the deceased himself e.g. history of drug or solvent abuse, self injury or overdose
- The death could be due to industrial disease or related in any way to the deceased employment e.g. asbestosis or mesothelioma
- The death occurred during an operation or before full recovery within 24hrs of the anaesthetic
- The death may be related to a medical procedure or treatment whether invasive or not
- The death may be due to lack of medical care
- There are any unusual or disturbing features to the case
- The death occurs within 24hrs of admission to hospital (unless the admission was purely for terminal care)
- Dehydration
- Septicaemia
- Any death where there is an allegation of medical mismanagement

**N.B.** This list is not exhaustive, but essentially one in which most deaths may fall. If in doubt contact the Coroner's Office for further advice

**Dorries C.P. (2004)** Coroner's Courts : A guide to law and practice
John Wiley & Sons : Chichester

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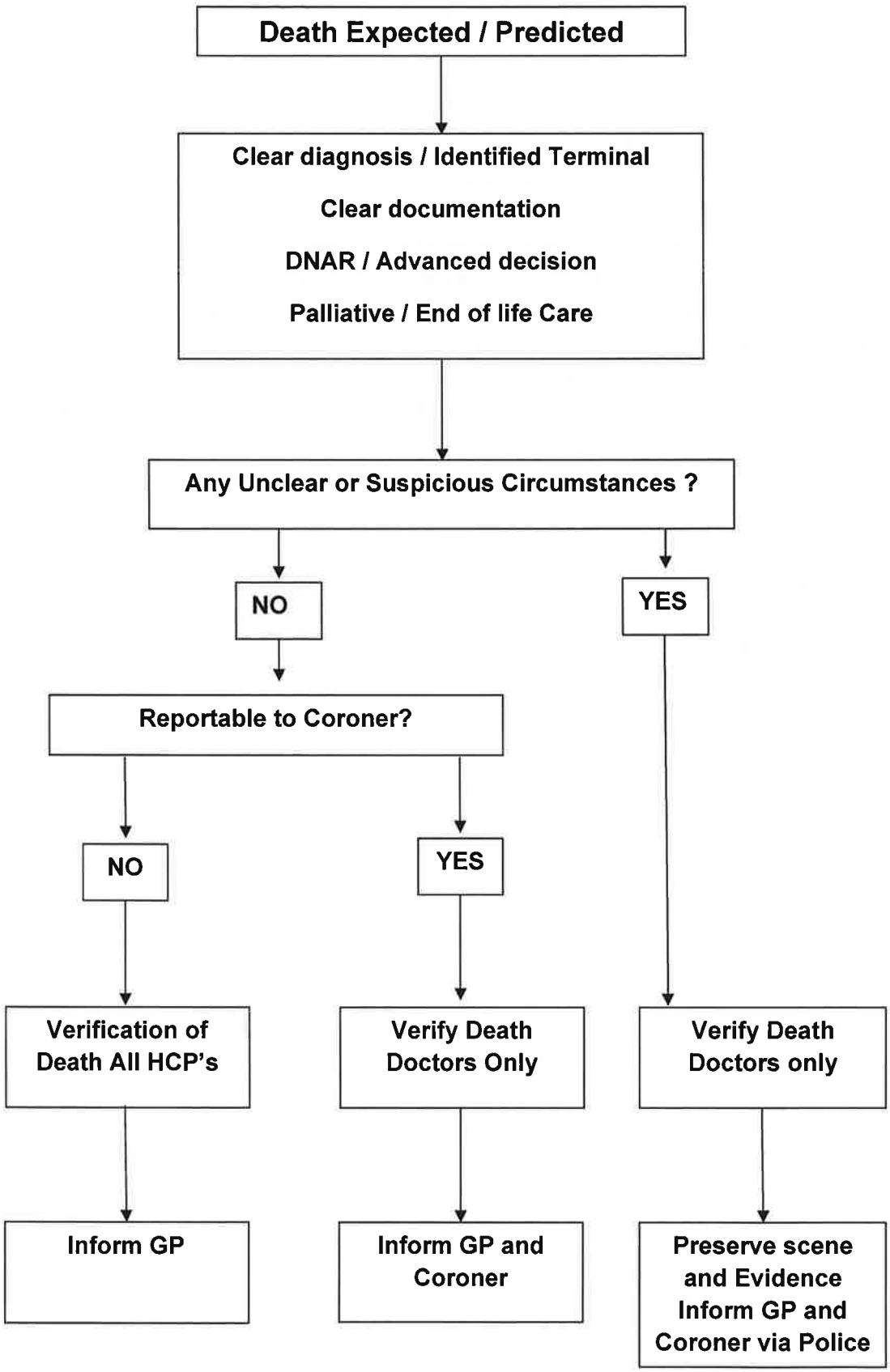
**Appendix B i** **Verification of Expected Death in the Community**



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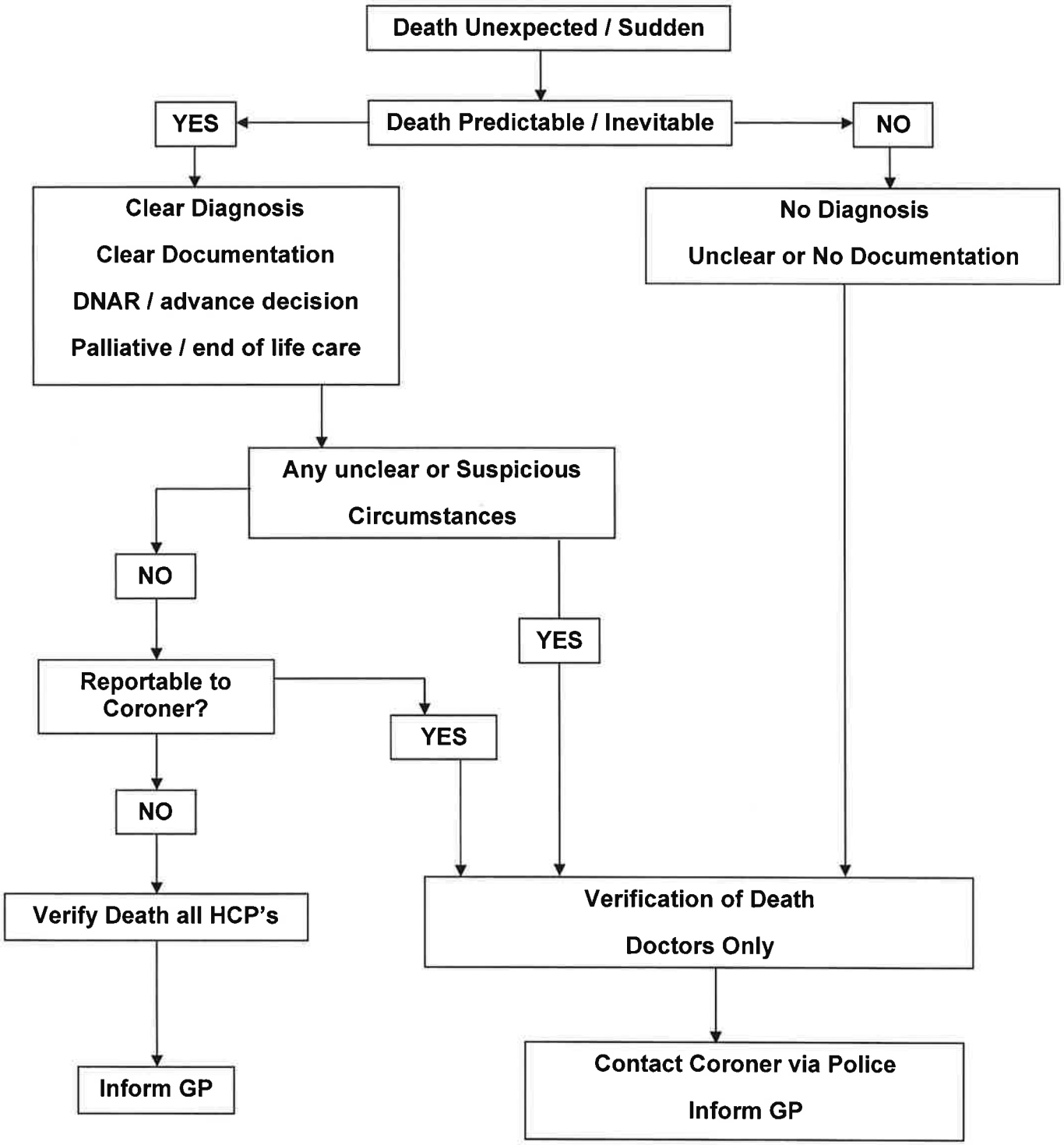
**Appendix B ii Verification of Unexpected Death in the Community**




**In all cases of unexpected and unpredicted deaths consideration must be given to the possibility of suspicious circumstances with preservation of the scene and potential evidence.**

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**Appendix C Verification of death record**

| **Verification of Death Record** | | |
|---|---|---|
| Full Name of Deceased: | Address: | |
| Date of Birth: | Sex: | |
| Place of Death:<br>Who identified body to you | | |
| Persons Present at Death (occupation/position/relationship to the deceased) | | |
| Date & Time Death Recorded (24 hour)<br>Date & Time Death Verified (24hr) | | DNAR in place **Yes / No** |
| Any devices/lines/tubes left in situ: | | |
| Infection present? | Infection control measures in place? | |
| Where was the body removed to? | | |
| Is there obvious injury?<br>If "Yes" have the police been informed of the death | | **Yes/No** |
| Has the Coroner been notified? | | **Yes/No** |
| Signs Noted: | Absent Respirations<br>Absent Heart Sounds<br>Pupils Fixed | **Yes/No**<br>**Yes/No**<br>**Yes/No** |
| Was the patient moved before verification of death made | | **Yes / No** |
| Name of person completing form: | | |
| Position / Occupation | Full Contact details: | |
| I verify the fact of Death<br>I authorise the removal of the body<br>I have informed the police | | **Yes/No**<br>**Yes/No**<br>**Yes/No** |
| Signed: | Date: | Time: |

**Comments**