Death of a Patient
Operational Policy for staff to follow in the event of a patient death

This procedural document supersedes: PAT/PA 32 v.1 - Operational Policy following the Death of a Patient and incorporates PAT/T 30 – Last Offices Policy.

PLEASE READ IN FULL

Transferred from the ‘Patient Administration’ section to the ‘Treatments/Investigations’ section.

NOTE: As of 1 November 2015 the Nottingham Coroner WILL NOT accept reporting of deaths occurring at Bassetlaw District General Hospital to Her Majesty’s Coroner for Nottinghamshire other than by electronic communication. (See Appendix 3(A) for process).

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The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.

<table>
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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

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<tr>
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<td>• Due to changes in the Standard Operating Procedure for the reporting of deaths occurring at Bassetlaw District General Hospital to Her Majesty’s Coroner for Nottinghamshire, information/process is added as Appendix 3(A) of this policy.</td>
<td>Mark Boocock</td>
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1. INTRODUCTION

Doncaster and Bassetlaw Hospitals NHS Foundation Trust is committed to ensuring empathic and efficient administrative support for the families and carers of the deceased to access appropriate information and care following bereavement and to ensure that provision is made for those people with special communication needs, and cultural variance. This includes those people who do not speak English or who may have sensory impairment or loss where communication is affected.

Interpretation Services are available upon request by contacting PALS or
- Doncaster Interpretation & Translation Unit (D.I.T.U.) on 08450176176 for face to face language interpretation only
- Big Word is for telephone language
- BID for the Deaf interpretation

2. PURPOSE

This guidance has been developed to ensure that services provided by this Trust are equally accessible to all parties of the communities it serves, and to advise Trust staff on how to access the services available. This policy covers care of patients who die in hospital or who are brought in dead. This policy does not cover end of life care and death in the community.

3. DUTIES AND RESPONSIBILITIES

ROLES / RESPONSIBILITIES / FUNCTIONS
It is every member of staff’s responsibility that this policy is upheld. The Trust has the right to expect that the standards in this policy are adhered to and line managers will regularly monitor adherence. All staff who are involved in the death of a patient and the subsequent support of the bereaved have a duty to abide by the relevant policy and guidance documents for their areas, which include roles and responsibilities, these include:

3.1 Chief Executive
The Chief Executive has overall responsibility for all policies and procedures within Trust.

3.2 Matrons, Managers and Senior Clinicians
Matrons, managers and Senior Clinicians have a responsibility to set the standard and ensure that the policy is followed at all times, ensuring that the deceased is treated with dignity.

3.3 Registered nurse/midwife
Follow all aspects of this policy, ensuring that the deceased is treated with dignity and relatives, friends and family are treated with compassion and respect. All documentation is completed promptly and accurately.
3.4 **Doctor**
Follow all aspects of this policy, ensuring that the deceased is treated with dignity and relatives, friends and family are treated with compassion and respect. All documentation is completed promptly and accurately.

3.5 **Chaplain**
Provide appropriate spiritual support and refer on to other agencies where appropriate.

3.6 **Bereavement officer**
Follow all aspects of this policy, ensuring that relatives, friends and family are treated with compassion and respect. All documentation is completed promptly and accurately.

3.7 **Mortuary staff**
Follow all aspects of this policy, ensuring that the deceased is treated with dignity and relatives, friends and family are treated with compassion and respect. All documentation is completed promptly and accurately.

3.8 **Professionals Performing Last Offices:**
Health care professionals have a legal duty to prepare a body in accordance with Coroner requirements if a post mortem examination is required.

Health care professionals are responsible for ensuring that a body is prepared for mortuary in accordance with the principles of infection control and health and safety, ensuring that dignity is maintained at all times.

To act in accordance with professional codes of conduct and practice and to ensure appropriate supervision of any non-registered staff undertaking this duty and make certain that anyone whom the professional delegates duties to is able to carry out instructions to meet the required standards.

3.9 **Health care support workers**
To undertake delegate duties in accordance with Trust policy ensuring the deceased and their family are treated with respect, dignity and compassion at all times. Health care professionals are responsible for ensuring that patient’s valuables and belongings are packed carefully and documented in accordance with Trust policy.

Repeated disregard of this policy will be considered in line with the Trust’s Disciplinary Policy/Procedures.

4. **PROCEDURE**

4.1 **Identification**

See Patient Identification Policy PAT/PS 7

“In the event of death, identity band should not be removed from the patient’s body. A second I.D. band bearing additional details must be
attached prior to transporting the deceased to the hospital mortuary.
(For full information see section on Mortuary Transfers within policy)
The additional details can be hand written on the standard printed band”

It is the responsibility of a registered nurse/midwife to ensure that the information contained on the deceased’s identity bands is correct. In the event of a discrepancy in information, it is the responsibility of the registered nurse to rectify the problem immediately.

In the event that the deceased does not have an inpatient identity band in situ it is the responsibility of a registered nurse/midwife to prepare and attach two patient ID bands (see PAT/PS 7). The identity bands must be checked by a second registered nurse/midwife before being placed on the deceased.

If a deceased patient arrives at the mortuary without an identity band during routine hours, the mortuary staff will notify the relevant ward/department/unit manager. It is the responsibility of the manager to arrange for a registered nurse/midwife who knows the patient to attend the mortuary as soon as possible to identify the deceased patient and attach an appropriate identity band.

For deaths outside the hospital primary identification must be checked via personal identification bands/tags and verified with the person delivering the body (See - Brought in dead).

Brought in Dead (BID)
When people are certified dead on arrival to the hospital the Ambulance Service may transport the body to the mortuary (DRI and BDGH sites). In this case individuals from the ambulance or police service are responsible for confirming the identity of the patient. These individuals, along with the mortuary staff or service assistants/porters, are responsible for ensuring the deceased’s identity is accurately recorded on wrist and toe/ankle bands and applied to the body.

If the body is unidentified, temporary labels bearing the terms unidentified male/female/adult/child should be used. The admission time and date should be written on the temporary labels. This should be completed by whoever transfers the body i.e. ambulance / funeral director etc. Verbal patient details can be accepted from the funeral director or police handling the body.

4.2 Care after Death Procedure

This procedure should be followed for all deceased patients. Following this procedure, viewing of the deceased on the ward is still available and remains available until the deceased is transferred to the mortuary.

The exception to this is where the death is classed as a death in custody. Following a ‘death in custody’, these deceased are dealt with directly by the
police / coroner. In such situations, nothing relating to the deceased, the environment or the deceased themselves should be touched, allowing the police to take immediate control of the body and surroundings. All lines and devices should be left in situ and unless there is a safety risk, all devices left operating. All clinical notes should be made immediately available to the investigating officers. Staff should refer to ‘the policy for the care of prisoners & patients from high secure hospitals’ PAT/PA 10.

The bereaved are given a Bereavement Services Leaflet (WPR34870) which reiterates that a member of the Bereavement Services hospital staff will contact them the following morning, Monday – Friday excluding bank Holidays so that arrangements can be made to collect the Death Certificate. They are offered further help and advice that they may require and given the PALS contact number of 01302 553140, in case they wish to discuss concerns regarding the care the deceased received or information on the condition the deceased suffered from.

NB At this point, the chaplaincy are always available to offer spiritual and/or pastoral support if not already supporting the patient and carers. They can be contacted by switchboard.

Staff should not advise relatives when the certificate will be ready. This information can only be provided by the Bereavement Officer and make take more than a day to achieve. For example – delays may occur in situations due to doctors not being available or the death is being dealt with by the Coroner. See also appendix 3 for when to refer a death to the Coroner.

Last Offices is the care given to a deceased patient, which demonstrates our respect for the dead and is focused on maintaining privacy and dignity, fulfilling religious and cultural beliefs, and upholding health and safety requirements. This nursing procedure is also known as ‘laying out’. This policy describes the care that is given when a patient dies to prepare the body for transfer to the mortuary. A literature review was carried out to guide this policy. With regards to packing, there was scant evidence within the literature; therefore the guidance has been developed on consensus of good practice.

Performing last offices is the final demonstration of respectful, sensitive care that nurses offer patients and their families. It enables families to be aware that care and respect is ongoing after death, and also allows both health care professionals and family members the opportunity for closure in the relationship, which can be helpful in the bereavement process. Families may wish to spend time with their loved one on the ward after death prior to Last Offices being performed. In this situation, the body should be repositioned and the environment tidied, in order to allow this time to be dignified and peaceful. Offer support and information to family/carer regarding the procedure after death.
4.2.1 Legal Requirements:
Either medical staff or a senior nurse must verify the death. Verification of death should be documented in the patient’s notes. Following on from the 2012 NPSA signal, staff should follow the guidance contained within the Code of Practice for the Diagnosis and Confirmation of Death, Academy of Medical Royal Colleges (2008) when diagnosing and confirming death after cardiorespiratory arrest. Staff verifying death must ensure time of death is recorded only once all identified criteria are fulfilled. Medical staff must verify an unexpected death. If a patient has died unexpectedly, or if the coroner is to be informed for any reason, a post mortem examination will probably be required. Examples of such situations include sudden death, death after invasive procedure (e.g. surgery or endoscopies) or patient with industrial disease (e.g. mesothelioma). If you are unsure as to whether a post mortem will be required, consult with the medical team who can confirm whether they will issue a death certificate or whether the case needs to be referred to the coroner. If a post mortem is required leave all tubes/drains/lines in place and spigot any catheters/cannulae.

4.2.2 Cultural/Individual Requirements:
Practices relating to last offices may vary according to religious and cultural needs. Brief information regarding these variations is included within this policy, however further information is available from the chaplaincy department. See Appendix 1 for cultural variations.

It is good practice to sensitively discuss and document the patient’s wishes prior to death if the opportunity presents.

If the patient is on the Integrated Pathway of Care for the Dying, please complete the audit form and send to Clinical Audit.

4.2.3 Infection Control Precautions:
Out of the estimated 600,000 deaths per annum in the United Kingdom, two thirds occur in hospital. Deaths associated with a known or suspected infection account for less than 1%.

No particular risk of infection exists with the majority of cadavers. However, bacteria normally colonising the gut, respiratory tract, genital tract can leak into previously sterile sites such as blood, muscle and lung, after death. Additionally, as body functions cease after death, there may be leakage from orifices to cause local contamination of the skin and environment. Therefore, the whole body should be regarded as potentially contaminated and Standard Infection Control Precautions applied. PAT/IC 19

In certain situations there may be an additional risk due to a particular infection which may be spread by:

- Airborne droplets or particles especially from lungs
- Discharges from the gut
- Inoculation risks
- Skin lesions
The risks and additional precautions necessary (e.g. body bags) relating to specific infectious diseases, confirmed or suspected, are listed in Appendix 3.

4.2.4 Procedure for Preparation of the Body (Last Offices)
The procedure should be carried out within 2-4 hours of the death. Each ward will have a Last Offices Kit containing this policy and all equipment necessary to prepare the body. Any religious requirements / preferences must be taken into account as far as possible.

- Ensure adequate privacy and dignity whilst performing last offices.
- Two members of staff should carry out last offices. Identity must be confirmed by two persons one of whom must be a registered nurse / midwife / professional.
- If not previously documented, wherever possible determine from the family or carers, the patient’s previous wishes for care after death.
- Wash hands and put on disposable gloves and plastic apron.
- Lay the patient on his / her back, straightening the limbs. Remove all but one pillow. Support the jaw by placing a pillow or rolled up towel on the chest or underneath the jaw. Do not bind the patient’s jaw with bandages as this can leave pressure marks on the face which can be difficult to remove. However, if the body cannot be straightened, force should not be used as this can be corrected by the funeral director.
- Close the patient’s eyes by applying light pressure to the eyelids for 30 seconds. If this is unsuccessful, then tape such as “Micropore” can be used which leaves no mark. Alternatively, moistened cotton wool may be used to hold the eyelids in place.
- Remove all mechanical aids, syringe drivers, heel pads, etc from the body.
- Remove all tubes, drains, cannulae etc, unless the coroner is likely to be informed of the death. In circumstances where the death is to be referred to the coroner, all tubes etc. must be left in situ. Central Lines and other intravenous lines that need to be left in situ must be covered with a waterproof dressing. A record must be kept in the patient’s notes of any devices left remaining.
- Stoma bags must always be left in situ. However, a clean stoma bag must be used.
- Drain the bladder by applying firm pressure over the lower abdomen. Have a disposable receptacle at the ready to collect urine.
- The mouth, nose and pharynx should be packed with cotton wool. This should not protrude from the mouth and nose. Leakages from the
vagina and bowel can be contained by the use of suctioning, drainage and incontinence pads respectively.

- Exuding wounds or unhealed surgical scars should be covered with a clean absorbent dressing and secured with an occlusive dressing. Stitches and clips should be left in situ.

- Wash the patient unless requested not to do so for religious / cultural reasons or carers preference. Male patients should be shaved unless they chose to wear a beard in life. Apply a water based emollient cream to the face after shaving. It may be important to the family / carer to assist with washing.

- Clean the patient’s mouth using a foam stick to remove debris and secretions. Clean dentures and replace them in the mouth if possible. If this is not possible, send the dentures to the Mortuary with the body and document this on the death notification form.

- In line with the valuables policy, all jewellery must be removed other than the following items:
  - Wedding Ring
  - Jewellery worn for cultural/religious reasons

  (See Appendix 1 for cultural variations) This must be performed in the presence of a registered nurse

- Jewellery left on the patient must be clearly documented on the “notification of death” form. Avoid the use of names of precious metals or gems when describing jewellery to prevent later confusion. Instead, use terminology such as “yellow metal” or “red stone”. Rings left on the body must be secured with tape if loose.

- Dress the patient in personal clothing or shroud, depending on relatives’ wishes. If a post mortem is to be undertaken the deceased should be dressed in a shroud.

- The above procedures should be carried out, if possible before the relatives are invited to view / spend time with the deceased on the ward.

Patient identification labels must be attached to both the wrist and ankle. All deceased patients must be sent to the mortuary wearing their original inpatient identity band. This must not be removed or replaced during the last offices process. An additional identification band will be added bearing the full name and address of the deceased, age and date of admission (see Patient Identification Policy PAT/PS7). The additional details can be hand written on a standard printed band. The admission time and date should be written on the temporary labels of any unidentified bodies.

- Clinical support workers and health care students may prepare and attach an identity band (providing they have undertaken the necessary
theory and practice) under the supervision of a registered nurse/midwife. It remains the responsibility of a registered nurse/midwife to ensure that the information contained on the identification labels is correct. **In the event of any discrepancy in information, it is the responsibility of the registered nurse/midwife to rectify the problem immediately.**

- In the event that the deceased does not have an inpatient identity band in situ it is the responsibility of a registered nurse/midwife to prepare and attach the two patient ID bands (see PAT/PS 7). The identity bands must be checked by a second registered nurse/midwife before being placed on the deceased.

- If the body is unidentified, temporary labels bearing the terms unidentified male/female/adult/child should be used.

- Loosely wrap the body in a clean sheet, to allow access to the deceased’s limb bearing the ID band. At the time of transfer to the Mortuary, it is the responsibility of a registered nurse/midwife to confirm with the service assistant transferring the deceased that the deceased’s identity is correct. The registered nurse/midwife will check with the service assistant that the information contained on the ID band matches the deceased’s records and notification of death form. The registered nurse/midwife and the service assistant will both sign the notification of death form confirming that this check has been undertaken and that the details are correct.

**The deceased must not be released from the ward for transfer to the Mortuary until the specified identification checks have been undertaken and correct identity confirmed.**

- Once identification has been confirmed, the sheet can then be secured ensuring that the face and feet are covered and that all limbs are held securely in position.

- Secure the sheet with tape.

- Place the patient in the body bag if appropriate. A body bag should only be used in situations where an infection hazard has been identified (see **Appendix 2 - Guidelines for Handling Cadavers with Infections Notifiable in England and Wales**) ensuring that the zip fastenings close at the head end of the body.

- Tape the “Notification of Death of a patient” form on the outside of the sheet or body bag.

- If the patient is a danger of infection risk, then use the **“Danger of Infection”** sticker and apply to the outside of the body bag - PAT/IC 11.

- The service assistants/porters and mortuary staff must be informed that the body is a known infection risk. Details of actual diagnosis should not be given for reasons of confidentiality.
- Remove gloves and apron and dispose of equipment in accordance with trust policy. Wash hands thoroughly. PAT/IC 5.

- The ‘Notification of the death of a patient’ form must be completed for all deceased patients by the registered nurse/midwife or doctor verifying the death in consultation with the ward nursing staff. The mortuary staff will inform the funeral directors of any infection control hazards associated with the body.

- The notification of death form WPR 17042 is:
  - Put in the notes
  - Sent to the bereavement office

- It is the ward staff responsibility to identify the next of kin and their contact details.

**4.2.5 Viewing of the Body**

Many relatives may want to view the deceased. This can take place either on the ward/mortuary viewing room or with the funeral director. Once within a body bag, the family may still view the patient unless they have been classified as posing a “High Risk” for infection (see Appendix 2). Viewing of a “high infection risk” patient by relatives is possible but this is via the window in the viewing room. Relatives should be encouraged to view the body before removal to the mortuary / funeral director.

It is imperative that patient confidentiality must always be maintained, irrespective of infection status. Therefore, if relatives are not aware of the presence of the disease, explanation of the additional labelling and infection control precautions being carried out must be dealt with, with great care and sensitivity.

**4.2.6 Deaths which occur in departments**

Given the diversity of departments across the Trust, clinical departments are expected to have a local policy to deal with situations where an unexpected event occurs which results in death.

**4.3 Handling Medicines following Death of a Patient**

This section should be read in conjunction with the medicines policy. Following the death of a patient, medicines shall normally be sent to the Pharmacy for destruction in the ward/department transit box. However, where harm is suspected as a result of medicines administered, any medicines in use shall be retained on the ward until the death certificate and/or investigation has been completed.
4.4 Transfer of the Deceased to the Mortuary

Following completion of Last Offices, the Service Department is contacted to transfer the deceased in an enclosed transfer vehicle. Prior to transfer to the Mortuary the identity of the deceased will be confirmed by a registered nurse and the attending service assistant. The information contained on the deceased’s identity band will be checked against the deceased’s medical records and the notification of the death of a patient form. (See Appendix 1 section 5). The registered nurse/midwife/Allied Health Professional and the service assistant will both sign the notification of death form confirming that the deceased’s identity has been checked and is correct on the identity band and notification of death form (WPR17041).

Under no circumstances should a body be transferred to the Mortuary until the specified identification checks have been undertaken and the deceased’s identity confirmed. All completed documentation must accompany the body to the mortuary.

It is expected any transportation of cadavers is performed with respect and discretion, the body should be transferred from the bed to the gurney using appropriate moving and handling techniques i.e. the use of a slide sheet to assist in transfer of the patient. The body being transferred through those areas not regularly accessed by the general public i.e. utilise service lifts and basement corridors. Where it is anticipated the general public may witness the transfer it is advised that every effort is made to reduce or stop the movement of the public during this process. It is important that the service department ensure that their staff are trained appropriately for this task and appropriate training and competency records are maintained.

4.5 Viewing of the Deceased by Relatives and Friends

Whilst it is unusual to refuse a request to view the deceased, there may be occasions when this is not appropriate, particularly when the body may be altered, discoloured or odorous to a degree when the bereaved would be distressed.

Caution should also be applied as there may be occasions when the person making the request is neither known nor welcome to the next of kin. When in doubt the next of kin must be contacted to ensure their agreement. Each case should be considered individually. Staff need to be aware that children of the deceased all carry equal status so that in situations were there is a split in the family one daughter/son can not instruct staff that another daughter/son cannot view.

It is expected that the person accompanying the relative is a registered professional, preferably who knows the family. In cases where this is not possible this must be escalated urgently, prior to the viewing, to either the CSU matron of member of CSU management team in hours or the Clinical Site Manager out of hours. This is to ensure alternative safe arrangements can be made.
It is the responsibility of the professional accompanying the family to check that the correct body is viewed.

4.5.1 **Doncaster Royal Infirmary**

**Ward in-patients:**
In-patients – during working hours – contact bereavement services and out of hours contact the ward where the deceased died.

When the bereaved contact the Bereavement Office, the Officer will contact the service supervisor to prepare the body for viewing from the mortuary. The Officer will also contact the appropriate ward/department to ensure a member of the ward team is made available to escort the bereaved to the viewing room and remain with them until the viewing is completed.

When the bereaved approach the ward with their request; the ward will make the necessary arrangements with the service supervisor, whatever the time.

**Accident and Emergency Department:**
For A&E Deaths or Brought in Dead. The bereaved should be advised by the nursing staff to report to A&E Reception. A&E staff will liaise with the service supervisor to arrange suitable viewing appointments.

The relatives of persons admitted directly to the mortuary via the ambulance service, coroner’s service or inter hospital transfer should also report to A&E reception with their request.

Viewing of the deceased is normally between the hours of 8.30 am and 4.30 pm; however this can be arranged outside of these times by arrangement with the service supervisor, when a special appointment can be made.

Relatives will be accompanied to the viewing area by a member of the department team who will remain with them until the viewing is completed.

4.5.2 **Bassetlaw General Hospital**
Viewing the deceased can be arranged by telephoning the Mortuary direct on 01909 500990 ext 2814 between the hours of 8.30am and 4.00pm and appointments can be made. Relatives should be advised to report to the relevant ward, Accident and Emergency reception or to the General Office and will be escorted to the viewing area by a member of the ward/department team or a member of the Bereavement Care Team who will remain with them until the viewing is completed. The mortuary assistants prepare for the viewing of the deceased only, the supervision of the viewing must be conducted by the relevant ward staff.

There is no mortuary staff on site outside the hours of 08.30 to 16.00 Monday to Friday. Viewings will only be conducted outside of these hours.
in exceptional circumstances. If required, hospital staff can contact the on-call mortuary assistant through switchboard.

4.5.3 Montagu Hospital
Viewing is arranged by the Service Supervisors between the hours of 8.00am and 4.00pm, Monday to Friday (excluding bank Holidays) and 8.00am and 1.30 pm on Saturdays. The Service Supervisor can be contacted on 01709 321111 extension 5665. Any arrangements out of hours can be made directly to the appropriate ward.

4.5.4 Maternal Death
It is a Trust and statutory requirement to report all maternal deaths up to 1 year following birth, irrespective of the reason for the death.

A maternal death is defined as a woman dying during pregnancy, or within 1 year of birth, termination of pregnancy or miscarriage CEMACH 2007.

The Head of Midwifery should be informed within working hours, at other times the labour ward co-ordinator and on call Supervisor of Midwives should be informed. This should occur as soon as possible.

4.5.5 Child Death
In April 2008, Child Death Overview Panels (CDOP) were established as part of all Local Safeguarding Children Boards in line with government guidance outlined within ‘Working Together to Safeguard Children’ (HM Government 2006 & 2010). The guidance stipulates that all child deaths (excluding stillbirths and planned medical terminations) up to the age of 18 should be reviewed. The purpose is to understand more fully about the circumstances surrounding individual child deaths and to identify themes and trends regarding all children in order to develop strategies to prevent the deaths of other children in the future.

Should any child under 18 years of age die within Doncaster or Bassetlaw the staff involved must inform the Rapid Response to Unexpected Child Death Team.

The Rapid Response Team work on a Rota basis and this is distributed to key areas in the hospital including the switchboards at Doncaster and at Bassetlaw Hospitals. The on-call member can be contacted via switchboard 9am-5pm seven days a week.

4.5.6 Bariatric Patients – See policy CORP/HSFS 4

4.5.7 Further Support and Guidance for Carers
Staff may deem it appropriate to offer family additional helpful information this includes:

Information that can be found on [www.dyingmatters.org](http://www.dyingmatters.org)
The Chaplaincy department are happy to see family members/carers soon after the death of a patient if that is appropriate and can direct them towards appropriate agencies for longer term support.

### 4.6 Organ Donation/Transplantation

Refer to Trust Policy PAT/PA 8.

Organ and tissue donation is supported by Doncaster and Bassetlaw Hospitals NHS Foundation Trust. Therefore tissue donation should be considered with all patients who die within the Trust.

Tissue services are a team of specialist nurses who will approach families re tissue donation. Tissue can be donated by most patients who die within the Trust, and age is not a barrier. Tissues can be donated up to twenty four hours following death.

Tissue services are based at Bridle Path Leeds and can be contacted on a twenty four hour pager system on 08004320559.

The resident Specialist Nurse in Organ Donation is based on Critical Care and can be contacted regarding any donation issues on 07525299087 during office hours Monday-Friday.

#### 4.6.1 Consent requirements

The Human Tissue Act 2004 sets out a legal framework for the storage and use of tissue from the living and for the removal, storage and use of tissue and organs from the dead. The Act also established the Human Tissue Authority (HTA) as a regulatory body for all matters concerning the removal, storage, use and disposal of human tissue for scheduled purposes. The Human Tissue Authority has issued codes of practice which are available on the HTA website: [http://www.hta.gov.uk/guidance/codes of practice.cfm](http://www.hta.gov.uk/guidance/codes of practice.cfm)

Please refer to the Trust Consent Policy (PAT/PA 2) for full details around consent.

Consent is only related to hospital post mortems, which should be obtained through the Bereavement Office procedures. Ward staff are advised to inform the Bereavement Officer and the appropriate doctor if family voice the view they want a post mortem.

### 4.7 Hospital Post-Mortem Examination

Anyone seeking consent for a hospital post-mortem examination should be spoken to by some one who is sufficiently experienced and well informed, with a thorough knowledge of the procedure for example the most senior member of the medical team available. They should have been trained in dealing with bereavement, in explaining the purpose and procedures and they should have witnessed a post-mortem examination. (See Human
Tissue Authority Code of Practice 1 Consent Part 1 paragraph 52, 53 & 54 for all further guidance.

Post-Mortem examinations should be carried out on premises licensed by the H.T.A. (see Human Tissue Authority Code of Practice 3 – Post-Mortem Examinations, Section HTA Standards) – currently the mortuary facilities at Doncaster Royal Infirmary are licensed for this purpose

4.8 Contract Funerals

The Trust has arrangements with local funeral directors when there are no next of kin/family members or no financial support from other sources. All requests and queries should be escalated to Bereavement Services.

4.9 Release of Bodies

In ordinary situations, relatives can arrange their own funerals without a funeral director, whereby they arrange removal of the body which would not require the Coroner to be informed. In this situation, if cremation is the disposal method, the Trust has to forward the completed cremation form directly to the crematorium and not given to the family. In such situations direct guidance should be sought from the duty Clinical site manager and pathology manager.

**Bodies cannot be released if there is to be a Coroner’s Post Mortem, or if there is a significant infection risk.**

Guidelines to enable the rapid release of bodies from the premises of the Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

This may take place in the following situations:

- Those whose faith requires disposal as soon as possible (within 24 hours preferably) this request in our area is most likely to come from members of the Muslim community but it could come from anyone for cultural or personal reasons.
- Rapid release of a body is also important, when possible, by members of the Jewish faith. In our area, the Jewish population is very small but we have and may receive requests from the families of Jewish patients.
- A family may wish to have the body of a deceased patient taken to another country for burial or cremation. The Coroner must be informed before release, if a body is to be taken out of the country.
- It is not a requirement of either the Muslim or Jewish faith for a body to be buried in another country. It may however be requested for cultural or personal reasons.
- A body can only be released if there is a signed Medical Certificate of Cause of Death and there is not a requirement for a Coroner's Post Mortem.
Following a ‘death in custody’, these deceased are dealt with directly by the police / coroner and do not go to our mortuary. Staff should refer to ‘the policy for the care of prisoners & patients from high secure hospitals’ PAT/PA 10

If unsure, then the case should be discussed with the Coroner’s Officer or a Consultant Pathologist. If a Coroner’s Post Mortem is required then this MUST be completed before the body can be released and the body must go to the mortuary for the examination. It may be possible to ask for the post mortem to be scheduled to allow a quick release for bona fide reasons, but this will require discussion with the Coroner’s Officer, Mortuary Staff and Pathologist.

If no Coroner’s Post Mortem is required and there is no other reason preventing the release of the body then it may be released.

The body is taken to the Mortuary as usual and details are entered into the Mortuary Register as per procedure. If collection of the body is imminent then the body may not need to be placed in refrigeration but may remain decently covered in an appropriate area.

The Medical Certificate of Cause of Death must be completed correctly and signed by an appropriate doctor. It may well take time to find an appropriate doctor to undertake this task.

When the Bereavement Offices at DRI & BDGH and the General Office at MMH are closed, a Medical Certificate of Cause of Death Book is available as follows on the Trust sites:

- **DRI**: In the Department of Critical Care.
- **BDGH**: There is no formal procedure for this currently. The General Office Supervisor or the Switchboard Manager may be contacted to facilitate access to the General Office or a certificate may be able to be obtained from another site.
- **MMH**: Contact the nurse on call or service supervisor who have access to the keys to the General Office. The Cause of Death Certificate Book is kept in the large grey cabinet near the safe.

If Cremation is required (highly unlikely in the case of deceased Muslim & Jewish patients) then the Cremation form should be completed before the body is released from the Hospital. (It is a requirement for all doctors completing both parts of the form to view the body and discuss the case in order to complete the necessary forms).

The Mortuary Register is duly completed.

The Consultant in charge and the appropriate Department Manager/ Clinical Site Manager should be informed.

Details are recorded in clinical notes.
If there is a lack of agreement between relatives as to whether the body is to be released or not then the body must not be released until there is agreement. If in doubt discuss with the Consultant pathologist or Coroner and the body should proceed to the mortuary as usual.

If the removal is not to be undertaken by a recognised undertaker but by the family, then the Coroner must both be informed and a route to the destination given before the body is removed from the Trust premises. This applies equally if the body is to be moved to a nearby destination or one outside the jurisdiction of the local Coroner. The Coroner must always be informed if the body is to be taken out of the country.

Contact Details for Coroner’s Office:
Doncaster: 01302 320844
Out of hours, contact is with the Police. Ring 0114 220 2020 and ask for the Force Incident Manager

Bassetlaw: Nottinghamshire Coroner 0115 9412322 or 0115 9412324
Out of hours numbers are on answer phone message.

Contact Details for Registrar:
Please note a funeral cannot take place without the death having been registered, neither can the body be removed from the country.

Doncaster: 01302 364922 (Message in regard to urgent requests, out of hours, is on Office Answering Machine)

Bassetlaw: 01777 708631

Montagu: Registrar’s Office, Council Offices, 1 Main Street, Mexborough. (Monday-Friday 9.30 -12.30 only) 01302 735705

Contact Details for Muslim Community
(Please note there is no Mosque in the Bassetlaw Area.)
Doncaster Mosque: 01302 368336

Muslim Council of Britain: 0845 2626786
www.mcb.org.uk

Contact Details for Jewish Community
There are very few Jewish residents in Doncaster & Bassetlaw, but we may have to deal with a patient who is travelling and is then admitted. The Jewish Community in Sheffield have staff that would be happy to assist as needed.
Orthodox Synagogue: 01142 588855
Reform Jewish Congregation: 07719209259

There is always a member of the chaplaincy team on-call. They may be able to offer support or assistance. To contact the on-call Chaplain, ring
either the switchboard at DRI or BDGH and ask for the on-call chaplain to be paged.

4.10 Referral to Her Majesty Coroner

Doctors are required to refer a death to Her Majesty the Coroner in certain situations. As DBHFT crosses over two jurisdictions, we have to comply with the requests of both the Doncaster and Nottingham Coroner, the scenarios for referral differ for both Coroners.

The lists for referral to Doncaster Coroner and Nottingham Coroner can be found at Appendix 3.

5. TRAINING/SUPPORT

Training sessions are available and are accessed through the Training and Development Department on Consent, Integrated Pathway of Care for the Dying and Breaking Significant News. The latter two may be accessed directly with the Palliative Care Team also.

The Junior Doctors Handbook covers all the medical issues of this policy.

Last Offices training sessions are available for all staff to attend. To book training sessions please contact Gill Hinton, Clinical Skills Co-ordinator on extension 2884 at Bassetlaw Hospital or Pamela Whitehurst on extension 2914 at Bassetlaw hospital.

If you are unsure regarding any aspect of performing Last Offices, please contact the palliative care team on extension 3142 at Doncaster Royal Infirmary or 2981 at Bassetlaw hospital, or the mortuary technicians on extension 3526.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Failure to follow this policy will be reported via the adverse incident reporting mechanism. Any member of staff failing to follow this policy will be managed according to Trust policy and this may result in disciplinary action.

The following chart illustrates how compliance with this policy will be monitored.

<table>
<thead>
<tr>
<th>Monitoring what</th>
<th>Who</th>
<th>When</th>
<th>How Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID on arrival to Mortuary</td>
<td>Mortuary staff</td>
<td>X 10 patients quarterly</td>
<td>Presented to PSRG</td>
</tr>
<tr>
<td>Preparation of Body prior to leaving</td>
<td>Registered nurse</td>
<td>X 10 patients quarterly</td>
<td></td>
</tr>
<tr>
<td>ward/department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct completion of Notification of</td>
<td>Mortuary staff</td>
<td>X 10 patients quarterly</td>
<td></td>
</tr>
<tr>
<td>death form</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. DEFINITIONS

**Family** - applies to all family, relatives, next of Kin and indented close friends who are part of the identified extended family.

**Brought in Dead (BID)** - refers to those individuals who are already deceased on arrival at the hospital. This usually relates to individuals brought in by emergency ambulance.

**Last Offices** - is the procedure undertaken by staff (predominately nursing) to prepare the body for transfer from the ward / department to the mortuary.

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified.

A copy of the EIA is available on request from the HR Department.

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- Integrated Pathway of Care for the Dying
- Valuables Policy Ref: PAT/PA 12
- Guidance for doctors certifying cause of death F66 LET (Office for National Statistics)
- Cremation forms – CR4 Medical Certificate Cremation Regulations 2008 - 01/09
- Bereavement Service (all sites)
- Mortuary Standard Operational Policies (S.O.P) Contact Pathology Quality Manager
- Human Tissue Authority – Codes of Practice – [www.hta.gov.uk](http://www.hta.gov.uk)
- Consent Policy PAT/PA 2
- Consent Policy for Trust Post Mortems- (Pathology handbook – intranet)
- Patient Identity Policy PAT/PS 7
- Service Department Training Guidance & Competency Record
- Fetal loss between 14-24 weeks gestation: MSG 55b
- Stillbirth and Neonatal death: MSG-59
- Removal of the body of a baby directly from the ward: MSG 107
- Medicines policy
- CORP/HSFS 4 - Manual Handling Policy – incorporating Guidelines for Handling the Bariatric (Extremely Obese) Patient/Client
- PAT/PA 8 - Adult Organ Donation Policy - Departments of Critical Care
10. REFERENCES

- http://www.endoflifecareforadults.nhs.uk/publications/when-a-person-dies
  HSE. Controlling the risks of infection at work from human remains
Cultural/Religious Variations:

This section provides some general guidance in relation to specific requirements that may need to be undertaken following death. Not inclusive seek family views.

Please use this section for guidance only; individuals may have different preferences regardless of religion/culture. For further advice, please contact a member of the chaplaincy team via switchboard. Please follow the Human Tissues Act guidance for organ/tissue donation.

**Baha’i faith:** Cremation not permitted, burial should take place as near as possible to place of death. Baha’i relatives will wish to say prayers for dead. Routine last offices are acceptable.

**Buddhism:** Consider dying is a very important part of life and that it should be approached positively and in as clear and conscious state of mind as possible. Routine last offices are acceptable; however, the body should not be moved for at least one hour if prayers are to be said. Cremation preferred.

**Chinese:** Customs vary very widely in the Chinese tradition; therefore, it is difficult to speak for all Chinese. Mostly for adults, the body is bathed, and sometimes the body is dressed in white or old-fashioned clothing.

**Christianity:** Offer support of appropriate chaplain. *Roman Catholic* patients should be offered visit by priest to give Sacrament of Sick when dying, and may wish to have a rosary or crucifix in their hand. *Church of England* and members of other churches may also wish to have prayers said both in the last stages of the patient’s illness and after death.

**Christian Scientists:** Worship is kept free from ritual. Routine last offices are appropriate. Female staff should handle a female body. Cremation preferred, prefer to not have post mortem unless required by law.

**Hinduism:** Post mortems disliked unless required by law. Consult the family by asking whether they wish to perform last offices, as distress could be caused if non-Hindus touch the body. If family are not available, wear disposable gloves, close the eyes and straighten the limbs. Do not remove jewellery, religious objects or sacred threads. Do not wash the body, as this is part of funeral rites and will usually be carried out by relatives using Ganges water. Wrap the body in a clean sheet. Body is cremated.

**Jainism:** Prefer no post mortem unless required by law. Prayers are offered for soul of dying patient. Presence of a Jain Spiritual Caregiver is preferred. Family may wish to assist with Last Offices. Body is cremated.
Jehovah’s Witnesses: No objection to post mortem. No special practices for the dying, but will appreciate a pastoral visit from one of their elders. Routine Last Offices are appropriate. May be buried or cremated.

Judaism: Prefer no post mortem unless required by law. Cremation is forbidden. Dying person should not be left alone, may wish to hear special psalms and prayers, can be said by a relative or Rabbi. Patients must not be washed and should remain in the clothes in which they died. The body will be washed in a ritual purification. It is important that the body is released to family as soon as possible.

Mormon: Do not object to post mortem. No rituals for dying, however spiritual contact is important. Routine last offices appropriate, if wearing a sacred undergarment must be replaced on body following last offices. Burial is preferred.

Muslim: Prefer no post mortem unless required by law. Patients may wish to face Mecca (South East). Family/friends may sit with patient reading the Holy Quran and making supplication. At death do not wash the body. Where no relatives are available, staff should wear gloves to avoid direct contact with the body. The body should face Mecca and the head should be turned towards the right shoulder before rigor mortis begins. The body can be made respectable by combing hair and straightening limbs, however the family will ritually wash the body before burial. The body of a female should be prepared by a female member of staff and vice versa for a male body. It is important to bury a body as quickly as possible.

Plymouth Brethren: As death approaches family may wish to keep a 24 hour vigil. After death the family may wish to attend to Last Offices themselves. Prefer no post mortem unless required by law.

Quakers: Do not object to post mortem. No special rules or practices for the dying, will appreciate a visit from an Elder or other Quakers who may sit in silent worship.

Rastafarianism: Post mortem is extremely distasteful to most Rastafarians, unless required by law. Routine last offices appropriate. Burial preferred.

Romany origin: Many people of Romany origin are Christians. If a traveller is dying, family/friends from around the country will wish to visit before death, meaning that there will often be many visitors. After death, the family will request that the person be laid out in clothing of their choice.

Sikhism: No objection to post mortem, however prefer not to if possible. Sikh men wear the five K’s: kesh (long hair kept under a turban), kangha (a small comb worn in the hair), kara (steel bracelet or ring worn on right wrist), kachha (special type of underwear) and kirpaan (sword worn symbolically by baptised Sikhs. After death routine last offices may be performed, but the 5 K’s should not be removed. Body is cremated.

Zoroastrian/Parsis: No religious objection to post mortem. Routine last offices are appropriate. Believe it necessary to commence prayers as soon as possible after death. No preference for burial or cremation.
APPENDIX 2

Biohazard guidance on the management of known or suspected infections which need precautions after death

<table>
<thead>
<tr>
<th>Infection / condition</th>
<th>Body bag</th>
<th>Viewing</th>
<th>Hygienic preparation</th>
<th>Embalming</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intestinal infections</strong>: transmitted by hand-to-mouth contact with faecal material</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysentery</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Typhoid / paratyphoid fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cholera</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Profuse diarrhoea / food poisoning</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Blood borne infections</strong>: transmitted by contact with blood via skin-penetrating injury or broken skin or splashes to eyes, nose and mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B and C</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>HIV</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Intravenous drug user</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Respiratory infections</strong>: transmitted by breathing in infectious respiratory discharges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Meningococcal meningitis/ septicaemia</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Meningitis (non-meningococcal)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Contact</strong>: transmitted by direct skin contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive group A streptococcal infection</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>MRSA</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Other infections</strong>:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viral haemorrhagic fevers e.g. Lassa fever,</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disease</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Transmissible spongiform encephalopathies e.g. CJD/vCJD</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Anthrax</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Plague</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Rabies</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Relapsing fever</td>
<td>Adv</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Adv = Advisable and may be required by local health regulations

* Requires particular care during embalming

See also:
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1200660061555
HSE. Controlling the risks of infection at work from human remains


Definitions:
**Body Bag:** placing the body in a plastic body bag.
Viewing: allowing the bereaved to see, touch and spend time with the body before disposal.

**Embalming:** injecting chemical preservatives into the body to slow the process of decay. Cosmetic work may be included.

**Hygienic preparation:** cleaning and tidying the body so that it presents a suitable appearance for viewing (an alternative to embalming).

**Other situations in which a body bag should be used:**
- Known intravenous drug user
- Severe secondary infection
- Gangrenous limbs/infected amputation sites
- Large pressure sores (e.g. grade 4)
- If body fluid leakage present e.g. coagulation disorder

Always consider the people who will be handling the body after it leaves the ward. Document any infectious disease on the notification of death form to allow mortuary staff to communicate this to funeral directors.
APPENDIX 3

When to Refer to Coroner:

Patients who die at Doncaster Royal Infirmary & Mexborough Montagu

A death should be referred to HM Coroner in the following circumstances:

- The cause of death is unknown;
- It cannot readily be certified as being due to natural causes;
- The deceased was not attended by the doctor during his last illness or was not seen within 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);
- 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 with an abortion;
- The death might have been contributed to by the actions of the deceased (such as a 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;
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred);
- 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 other unusual or disturbing features to the case;
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care);
- It may be wise to report any death where there is an allegation of medical mismanagement.

This note is for guidance only, it is not exhaustive and in part may represent desired local practice rather than the statutory requirements. If in any doubt contact the Coroner’s Office for further advice.
Patients who die at Bassetlaw District General Hospital

A death should be referred to HM Coroner in the following circumstances:

1. The cause of death is not known.

2. Deceased had not been seen by a medical practitioner within 14 days prior to death.

3. Deceased had not been seen alive by certifying doctor.

4. Cause of death may be due to trauma or unnatural cause e.g. Road Traffic accident, apparent taking of own life, poisoning, self harm, fracture, evidence of violence.

5. Cause of death may be related to an industrial disease e.g. pneumoconiosis if the deceased was a miner, mesothelioma if the deceased had been exposed to asbestos, farmer’s lung or the deceased had died due to an injury sustained in employment (Please refer to the reverse of the death certificate to see a comprehensive list.)

6. Patient had been in hospital for less than 24 hours.

7. Cause of death is due to a fall or there has been a fall in the three days prior to death.

8. At time of death, a grade 3 or grade 4 pressure sore is present or more than one grade 2 pressure sores are present.

9. Surgery or invasive procedure involving general or local anaesthetic performed within the preceding 12 months (including endoscopies).

10. Significant medical procedure or treatment (including chemotherapy or radiotherapy) during index admission.

11. Person deprived of their liberty or liberty was restricted by law at the time of death, in seven days preceding death, including a serving prisoner or a person detained pursuant to Mental Health legislation.

12. Alcohol or any prescribed or non-prescribed drug is mentioned as contributing to the cause of death in part 1 of the death certificate.

13. Death during pregnancy or within a year of giving birth.
14. All deaths that would be referred to the Child Death Overview Panel (CDOP) i.e. all paediatric deaths.

15. Allegations of negligence during or prior to admission regardless of whether these are considered to be substantiated.

16. Death associated with (or after) a clinical incident.

17. If the patient is under the age of 80 and Old Age is given as the sole cause of death then you must report the death to the Coroner (please see note below).

18. Any other unusual circumstances.

19. If there is no apparent indication to refer to the Coroner but a significant and unresolved complaint has been received relating to patient care the Consultant in charge must consider if Coroner referral is required.

If there is any doubt about whether a Coroner’s referral is required, the first point of contact should be the Consultant in charge of the care. The Consultant has the ultimate responsibility for decisions on referral.

Deaths certified as Old Age

Please note that to give old age as a cause of death without referring to the Coroner you must:

a. Have personally cared for the deceased over a long period of time
b. Have observed a gradual decline in the patients general health and functioning
c. Not be aware of any identifiable disease or injury that contributed to the death.
d. Be certain that there is no reason that the death should be referred to the Coroner

This document has been prepared by Ruth Musson, Bereavement Service Team Leader in conjunction with Miss M Casey HM Coroner for Nottinghamshire.
Electronic Reporting of Deaths to Her Majesty’s Coroner for Nottinghamshire

The following applies only to deaths occurring at Bassetlaw District General Hospital

Deaths occurring at Doncaster Royal Infirmary and Mexborough and Montague Hospital should still be referred to the Coroner at Doncaster in the usual way.

As at 01 November 2015 the Nottingham Coroner WILL NOT accept reporting of deaths other than by an electronic communication. A system has been developed to allow web-form reporting by Doctors that is securely transferred to the Nottinghamshire Coroner from a General Office nhs.net email and any replies will be via General Office.

Process:

1) Ensure that you are logged into the computer you are using under your DBH Winframe ID
3) Once you have opened the Death Report certain fields will be automatically populated including your name as the reporting doctor, the date the matter is being reported
4) Enter the deceased patient’s District Number (D???????) into the relevant box; once you then click onto the next box the name, gender, marital status, date of birth, date of death and time of death fields will be automatically populated from CaMIS
5) If an incorrect D-Number is entered a message will appear saying “Whoops. Something went wrong. The patient is still alive” and you will not be able to submit the form. CHECK THE D-NUMBER IS CORRECT. This will also occur if CaMIS has not been updated with a Date of Death. Should this be the case, stop the reporting process, access CaMIS, update the date of death and time of death if known and then restart the death reporting process
6) Enter relevant details against each heading or question; where there is a box this is free-text for you to type in details, where there is a yes/no button a “details” box may appear if you answer yes and details entered if known
7) Registered GP details will be automatically updated from CaMIS
8) Under Reason for reporting death this is a drop-down function, click “Select Reason” and a drop-down list of reportable deaths to the Nottinghamshire Coroner will appear. Select the correct reason
9) YOU MUST ANSWER ALL THE QUESTIONS – failure to do so will lead to delays in the Coroner’s processes and ultimately delays for the deceased’s relatives in funeral planning
10) Set out your medical cause of death or give reasons why you cannot propose a cause of death
11) Answer the questions under For Internal Use Only – these are to assist with risk and inquest management processes
12) Press the “Submit” button; the report will automatically be sent via secure email transfer to the Coroner’s Office from a generic General Office nhs.net email
13) A copy of the reports will be stored in the admin area, accessible at [http://dbhlive01/workflow/admin](http://dbhlive01/workflow/admin) - if a print-off is required for the notes they can be accessed here.

14) The Coroner’s Office will be instructed to reply to [generalofficebdgh@nhs.net](mailto:generalofficebdgh@nhs.net).

15) Once the Coroner’s Office has replied, inform the relevant Doctor/Consultant Team with regard to instructions on issuing a death certificate or if the matter is for inquest.

16) Keep a copy of the completed form from the Coroner on the patient’s medical records.

17) A database of reports will be kept and accessed by Legal Services to identify trends, themes and risks and assist in forward planning for inquests.
Completion of Medical Certification Guidance

DEATH CERTIFICATION

- You are required to complete a Medical Certificate of Cause of Death, stating the cause of death to the best of your knowledge and belief, if you attended the deceased during his/her last illness. You must not complete the certificate if you did not attend the deceased during his/her last illness (e.g. patient brought in after attempted resuscitation was commenced in the community).

- There are 3 types of death certificate:
  1. Medical Certificate of Stillbirth (after 24 weeks of pregnancy).
  2. Medical Certificate of Cause of Death of a live-born child dying within the first 28 days of life.
  3. Medical Certificate of Cause of Death (any other death).

A death should be referred to the Coroner if:
- The cause of death is unknown.
- The deceased was not seen by the certifying doctor either after death or within 14 days before death.
- The death was violent or unnatural, or there are suspicious circumstances.
- The death was due to an accident or fall, whenever it occurred.
- The death may be due to self-neglect or neglect by others.
- The death may be due to an industrial disease or may be related to the deceased’s employment.
- The death may be related to an abortion/pregnancy.
- The death occurred during an operation or before recovery from the effects of anaesthesia or sedation.
- The death may be a suicide.
- The death occurred during or shortly after detention in police custody or prison custody.

It is advisable to discuss the cause of death with the senior staff of your clinical team especially if you are in any doubt as to whether a death should be reported.

**You must discuss the cause of death with your consultant before completing the death certificate.**

Document all discussions clearly/legibly in the medical notes and date them. In certain circumstances, a hospital post-mortem may be deemed appropriate, especially where a cause of death is known but more detailed information may be helpful e.g. in deaths from Metastatic Cancer from unknown primary.

**Cause of Death Statement**

- **Part 1**
  On the first line, state the disease or condition leading directly to the death
(Part 1a). On subsequent lines, complete the sequence of disease(s) or condition(s) leading to death as given in 1a – these must be directly related i.e., 1c should lead to 1b which should lead to 1a.

The disease or condition directly leading to death and the Underlying Cause of Death may be the same. In this case you need complete only the first line of Part 1 – 1a.

- **Part 2**
  If there is some significant condition or disease that contributed to the death but which is not part of any sequence leading directly to death, e.g. diabetes mellitus that is difficult to control in a patient with disseminated malignancy, you should record it in Part 2.

Do not state a mode of dying, e.g. ‘coma’, ‘organ failure’, ‘cardiac or respiratory arrest’, ‘cachexia’, ‘debility’, ‘uraemia’, ‘shock’, unless you also specify the disease or condition which preceded it, otherwise the Registrar will report the death to the Coroner as ‘cause of death unknown’. It is advisable to discuss the wording of the cause of death with senior medical staff of your team. The bereavement officers who are used to seeing death certificates may also be able to help.

Do not use abbreviations (e.g., CCF, COPD) or medical symbols.

Do avoid the use of ‘old age’ or ‘senility’ as causes of death UNLESS there is no other significant illness that can be related to the death, death is not reportable to the HMC, and the deceased is > 80 years of age

- **CREMATION FORMS**
  The junior doctor (usually the doctor who completed the death certificate) will be contacted by the mortuary or the bereavement officer to complete the first part of the cremation form (called Form 4). The second part (Form 5) is completed by another doctor who will need to speak to you and at least one additional member of the team caring for the patient in their last illness – so relevant names of involved team members must be provided.

When you complete a cremation form, you must view the body after death. You must confirm with a senior member of the team that there is no indication for a post mortem before you complete the first part of the Cremation form. It is a legal requirement for the doctor completing Form 5 of the form, to speak to the doctor completing Form 4 before the form is completed – so provide your contact details, details of leave and night duties.

If you anticipate being unavailable, consider requesting another team member to complete the form.

Payment for completion of the forms is a private transaction between the Funeral Director and the doctor (non NHS). The mortuary technician will accept payment on behalf of the doctor and will forward on the payment to the doctor.
APPENDIX 5

Reporting Deaths in Accident and Emergency
to the Coroners Office

Deaths in A & E → Out of Hours → Fax Information “After Death of Patient for Coroners Officer Form”

In Hours

Telephone Coroner’s Office (Sister in Charge)

On Following Morning (next working day)