

Care After Death

Guidance for staff
responsible for
care after death

National Nurse
Consultant Group
(Palliative Care)



Royal College
of Nursing

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Foreword

Caring for a person at the end of their life and after death is enormously important – for those who are dying, their families and others who are important to them. It is a highly individual experience that reflects cultural, religious as well as personal preferences and characteristics; as such it is an aspect of end of life care which calls on the skills of many different professionals and organisations to meet these many requirements.

Crucially, there is only one opportunity to ensure good care after death and it is not easy to coordinate everything that needs to happen. The guidance is therefore an important publication – highlighting good practice and confirming a process by which everyone who is involved can ensure that the experience for those coping with the loss of someone important to them is as good as it can be.

This second edition of the guidance builds on the first, which was generated for nurses and those who had nursing tasks delegated to them. It also had a relevance for health and social care professionals who worked with people at end of life. Following recommendations from the Institute of Health Care Management, which evaluated the first edition, the focus of the second edition has been extended to include deaths that occur in mental health and prison settings. It details key elements of care provision in the period immediately following death and its implementation will help to minimise duplication of roles or gaps in care.

Throughout the process of revising the guidance, many individuals representing organisations with a responsibility for caring for people after death have demonstrated a willingness to work together and share their professional expertise. The involvement and contribution of so many experts is to be commended. Our call now is for the guidance to be widely read and shared with colleagues, supported by organisations, and incorporated into relevant policies and protocols so that it becomes part of day to day practice.

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Introduction

In the first edition of *Guidance for staff responsible for care after death (last offices)*¹ the guidance was focused mainly for adults who die in acute hospitals, at home or in a care home setting.

The review of the impact of the guidance² identified that the guidance was useful in providing staff with the confidence and competence to perform care after death, and to speak to bereaved people. It also supported the teaching of students. However, the reviewers did make recommendations that related to training of staff, and addressing deaths in mental health services and prisons. This second edition addresses these recommendations.

It should be noted that this guidance is relevant for adults over the age of 18. Guidance for children and young people is addressed elsewhere³.

In line with the first guidance we will refer to 'care after death' rather than 'last offices' as this term is more befitting of our multi-cultural society, and reflects the variety of tasks of care at the time of death, including supporting the family and those identified as being of most importance to the dying / deceased. The physical preparation of the body itself will continue to be called 'personal care after death'.

In this document the term 'family' is used and represents family and those people identified as being of most importance to the dying / deceased person. The shortened version is used for brevity and ease of reading. In line with the Mental Capacity Act the legal role given to people holding a Lasting Power of Attorney (LPA) is recognised. With respect to organ donation and post-mortem examination,

however, consent needs to be sought from the person with the highest qualifying familial relationship⁴, unless the post-mortem examination is authorised by the coroner when consent is not required.

Existing work has been referenced where possible, and where this is not possible a consensus approach has been taken⁵.

The guidance relates to other concurrent work:

- Academy of Medical Royal Colleges – A code of practice for the diagnosis and confirmation of death⁶.
- Leadership Alliance for the Care of Dying People – One chance to get it right⁷.

and research:

- Bereaved families' experiences of organ and tissue donation, and perceived influences on their decision-making⁸.

All people die – some deaths are expected, for example, due to ill health. Some deaths are unexpected, either due to a sudden event, or to an accident / violent event. Those that physically care for the deceased at the time of death need to care for those who have died in either manner.

In 2012, there were 225,724 deaths in hospital, 102,617 at home, 98,135 in care homes, 26,525 in hospices and 9,592 in other places. It is challenging to work out the numbers of patients who are dying in mental health services settings and in prisons. Most (over 8,000) of the deaths in 'other places' are what the Office of National Statistics (ONS) described as 'elsewhere' – either a private address that is not the individual's own home, or in a public place. The remaining 'other place' deaths include over 150 described as 'psychiatric hospitals', 'psychiatric hospitals (security)' or 'psychiatric unit'.

The Ministry of Justice Publication *Safety in Custody Statistics England and Wales Update to December 2012*⁹ reports a total of 192 deaths in prison custody during 2012. Comparing that with place of death statistics, it is believed that many of those did not actually die in the prison but in the acute hospital¹⁰. This has been validated through feedback during the consultation where it is recorded that prisoners are transferred out of the prison if their symptoms cannot be managed there.

Thus it appears that the numbers of people who die in mental health services hospitals and in prisons are small, however with an ageing population this is likely to increase. Whilst there is evidence that it can be challenging to provide palliative care in a custodial setting¹¹, much work on end of life care in prisons, aimed at developing end of life care services, has already been undertaken^{12 13}.

The person who provides the care after death takes part in a significant process. Although care after death is based on comparatively straightforward procedures, it requires sensitive and skilled communication to address the needs of family members. Communication needs to be empathetic and clear, with any information tailored to those involved. For example, it needs to be age specific (to address the needs of children), and to take into account how individuals who have specific communication needs communicate, eg those with dementia or learning difficulties. Individuals should also be aware of local resources available to support both communication and families. National resources exist to support this aspect of care¹⁴.

It is a very difficult time for those who have been bereaved and can be especially emotionally challenging if the person providing the care after death has nursed the person in

life. This guidance recognises that competence to care for the deceased and support of their families must be included in all training programmes.

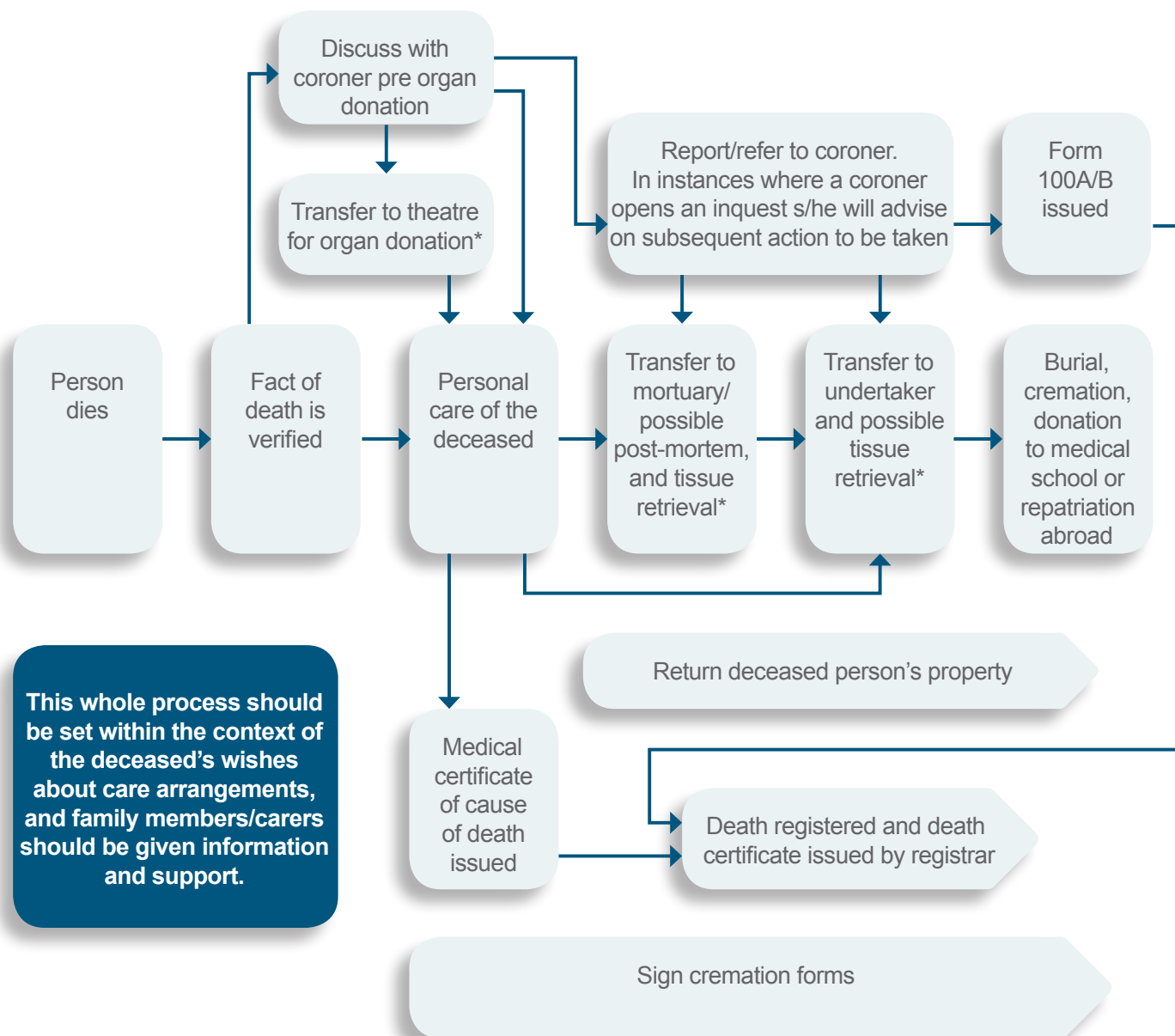
The diagram on page 8 shows that care after death (including personal care after death) is the first stage of a process that involves a range of professional groups. This process leads ultimately to cremation, burial or repatriation of the deceased. Personal care after death is usually the last act of care of nurses, but in some care settings, for example prisons, this may be the first act of care by funeral directors.

Professionals involved in care after death include doctors, nurses, mortuary staff, hospital porters, ambulance staff, bereavement officers, specialist liaison workers, eg those who support individuals with learning disabilities and their families, police, social care staff, funeral directors, pathologists, coroners, healthcare chaplains and faith leaders. Co-ordinated working between these individuals and organisations is vital if the process is to run smoothly.

Care after death includes:

- Respecting the religious or cultural wishes of the deceased and their family where possible, and ensuring legal obligations are met
- Ensuring timely verification of death
- Preparing the deceased for viewing, where appropriate, and supporting the family
- Offering family present the opportunity to participate in the process and supporting them to do so
- Ensuring, where relevant, that families are informed about the need for post-mortem examination and given information about tissue retention and disposal methods
- Preparing the deceased for transfer to the mortuary or the funeral director's premises
- Ensuring that the privacy, dignity and respect of the deceased is maintained at all times
- Ensuring that the health and safety of everyone who comes into contact with the deceased is protected
- Facilitating people's wishes for organ and tissue donation
- Returning the deceased's personal possessions to their relatives.

Processes of care for the deceased



* Organ donation can be facilitated for inpatients of acute hospitals and for prisoners. Tissue donation can be facilitated from any setting except prisons.

Legal issues

1. It is essential to comply with legal requirements¹⁵. See Appendix 1 for deaths that require an investigation by the coroner. It is worth noting that 45 per cent of all deaths were reported to the coroner in 2013¹⁶. All staff caring for the deceased need to ensure they are familiar with deaths that require such a referral as this will facilitate the correct personal care and enable staff to prepare the family both for a potential delay in the processing of the MCCD and the possibility of a post-mortem examination. When there is a death of a patient detained under the Mental Health Act or in custody it is always reported to the coroner, and is subject to an inquest. Such deaths will always be investigated by the coroner and police and for those in custody, by the Police Prisons Officer. A specialist forensic post-mortem examination is likely to be undertaken. The coroner's jurisdiction also extends to those who are detained under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Where the person was detained, or was liable to be detained, under the Mental Health Act at the time of death, the provider must notify the Care Quality Commission under Regulation 17 of the Health and Social Care Act 2008¹⁷. Forms are usually completed by the team responsible for the deceased's care.
2. Guidance is available on the care of vulnerable adults¹⁸. If a safeguarding issue becomes apparent after death, clearly documented concerns should be raised with social services, police and the coroner, in line with local processes and guidance.
3. Where the person had a known illness that requires referral to the coroner (eg mesothelioma) but dying was anticipated, it is not necessary to involve the police. Referral to the coroner does not automatically require a post-mortem, but a post-mortem can be useful to assess the extent of the disease or other factors contributing to death.
4. It is best practice, but not mandatory, for certifying doctors to see and identify the person before completing the MCCD. However, it is a legal requirement for both doctors completing cremation certificates 4 and 5 to have viewed and examined the deceased before completing the forms.
5. The certifying medical practitioner has overall responsibility for identifying and communicating the presence of any implanted devices or radioactive substances. They are also responsible for identifying the appropriate person to deactivate and remove implants, to liaise with the appropriate medical physics department regarding radioactive treatments and to advise mortuary staff and funeral directors. For information required by mortuary staff and funeral directors see Appendix 2.

Care before death

6. While it can be hard to identify when someone is dying, there is guidance regarding complex decision-making¹⁹ and care²⁰.
7. It is vital to assess the patient's mental capacity in line with the Mental Capacity Act and involve the patient in decision-making as much as they wish to be²¹. If the patient no longer has capacity it is vital to be aware of any previously documented advance decision to refuse treatments or advance statement of wishes (this should include their wishes about organ and tissue donation²²).
8. Early release from prison may be considered where a prisoner has a terminal illness and death is likely to occur soon^{23,24}. There are no set time limits, but three months may be considered an appropriate period and it is therefore essential to obtain a clear medical opinion on the likely life expectancy. The Secretary of State will need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison.
9. When all reversible causes of deterioration have been ruled out, and where dying is possible, it is important (if it has not already happened) that communication occurs between medical and nursing teams, patients and their families about clinical decisions, and that there is patient and family agreement wherever possible. These decisions can include whether to attempt cardiopulmonary resuscitation²⁵, whether treatment ceilings are required²⁶, whether organ / tissue donation is an option²⁷, and whether a hospital consented post mortem is likely to be requested. The Leadership Alliance for the Care of the Dying Person Priorities of Care suggest all dying patients have an individualised care plan that includes food and drink, symptom control and psychological and spiritual support. If an implanted cardiac defibrillator is in situ it is important to assess whether its shock therapies should be de-activated, as these may be triggered in the dying phase and cause discomfort²⁸ and can cause injury to pathology technicians and funeral staff if left activated. It is also helpful if the preferred place of death is ascertained as the achievement of patient choice is related to this being voiced²⁹. In mental health services and prison care settings the patient may need to be moved or special provision made locally with early advice from relevant experts. Unambiguous and documented communication on all of the above decisions ensures there is clarity about whether the death is expected or not and allows for appropriate preparation of the dying person and their family/carers.
10. It is good practice to identify and document in advance any religious, cultural or practical wishes the dying person and their family may have for the time of death or afterwards, particularly regarding urgent release for burial or cremation. This can be done as part of the advance care planning process³⁰ or it can be completed nearer the point of death.
11. All families should be advised that there is information available on the processes after death and they should be aware of how to access this. In a home setting for example, there should be information on who to contact to verify the death, how equipment is returned, how to dispose of drugs, the process for death registration and information about the coronial process and inquests. This information should be family and situation specific, and this

should be made available prior to the death of the person being cared for if required. This care planning is particularly important when the person is dying from mesothelioma³¹.

12. All families should be advised of support available, including immediate support from the care provider about care after death processes³² and on-going bereavement support, if it is required³³. Staff should be aware of people who may be at risk of complicated grief responses. Consideration of additional support should be made to young people under the age of 18³⁴, those bereaved in traumatic circumstances, people with learning disabilities, those who have suffered multiple bereavements and other areas of added vulnerability; their families should be advised of the need to inform their GPs and places of education and of the local support and resources available.
13. All providers of care after death should have prompt access to clothing and equipment to care for the deceased, including body bags. Particular attention should be paid to the needs of bariatric people, in order that they are clothed and moved safely³⁵.
14. In care home and home settings where death is expected, it is crucial that the GP reviews the person regularly and at least every 14 days, both from a care perspective and in order that a Medical Certificate of Cause of Death (MCCD) can be appropriately issued without involving the coroner.
15. Where there is a rapid, same day discharge home (to a private home, social care or mental health care setting) from

hospital for expected end of life care, and this occurs on a Friday, it is essential that there is a GP visit that day or the hospital consultant is happy to issue the MCCD, should the death occur at the weekend. Alongside the care planning – including equipment, care of the person's hygiene and nursing needs, and family support – the practicalities of who will verify the death and issue a MCCD, including the paperwork for cremation (cremation part 4 and part 5³⁶), should be considered. For rapid discharge from hospital to prison it is essential that the prison has 24 hour healthcare provision and the lead nurse is contacted to ensure the health needs of the dying prisoner is met.

16. Whole body donation can only be consented to by individuals themselves in life, and cannot be consented to by anybody else on their behalf after death. Guidance for professionals and the public is available³⁷. If an individual's wishes regarding organ and tissue donation were not formally recorded before death (eg in an advance statement, a registered and recorded consent to donate on the NHS organ donor register or a donor card) then consent can be sought by a healthcare professional, with appropriate training and skills³⁸, from a nominated representative or someone else in a 'qualifying relationship', observing the hierarchy of qualified relatives in the Human Tissue Act³⁹. Advice on suitability for organ donation is available from the Specialist Nurse in Organ Donation (SNOD) based within the acute NHS trust, or by contacting NHS Blood and Transplant (NHSBT) directly⁴⁰.

17. While organ donation can only take place within an acute trust, tissue donation can be facilitated in any setting other than a prison⁴¹. The registered health professional caring for the dying person and their family needs to contact NHSBT to assess donor suitability⁴². NHSBT will advise on the next steps, and it may be necessary to transfer the deceased to a setting where the retrieval of the tissue can occur. Where a death is reportable to the coroner, advice must be sought from the coroner before donation can proceed. In some cases permission will be refused, due to the legal requirement for the cause of death to be established and evidence to be gathered as to how the person died.
18. Some people will wish to be repatriated after death to another country. Only the coroner can give permission for the deceased to be moved from England and Wales, and the deceased will need to be embalmed and certified as free from infection. There is written guidance for professionals, individuals and families⁴³ and most funeral directors will co-ordinate the process.
19. Ask the person (if this is possible and/ or appropriate) who they wish to be present at the time of their death. If this is not possible, try to find out from the family, as well as details of how they wish the news of the death to be communicated if they are not present. Relevant contact details will need to be recorded and readily accessible by all appropriate staff. In prison settings the family liaison officer informs the family of the death.
20. Accommodate people's preferences for place of death wherever possible. In communal settings offer people and their families the option of single room accommodation (if available)⁴⁴. This can engender a feeling of homeliness, allows dying people to rest, gives them privacy and enables them to have family to stay for extended periods without intruding on others. Not all dying people, however, will want a single room and the evidence indicates that while it can be distressing for others to witness a death it can also be comforting when the process is well managed⁴⁵.

Care at the time of death

21. If present at the time of death, the registered nurse, doctor, ambulance personnel or appropriately trained healthcare worker needs to record the time, who was present, the nature of the death, and details of any relevant devices (such as cardiac defibrillators)⁴⁶, as well as their own name and contact details in the nursing, medical or ambulance documentation. If relatives have any concerns about the death these should also be documented (and in this particular instance it is important to maintain the deceased body and environment and seek advice from the coroner).
22. When death occurs inform the medical practitioner primarily responsible for the person's care. Verification of death needs to be completed by the doctor, appropriately qualified nurse⁴⁷ or ambulance personnel before the deceased is transferred from the care setting. Whilst recognising the need to attend to acutely unwell patients as a priority, if the verification of death takes an extended period then it can cause distress to family and if, in a communal setting, to other patients. In acute trusts it is helpful if verification occurs within one hour. In other settings it is helpful if it takes place in four hours. It is recommended that all care settings – including care homes - ensure adequately trained staff to verify expected deaths of patients in and out of hours. The role of GPs in verification of death for residents of care homes has been specifically addressed⁴⁸.
23. The death must be verified in line with the measures identified in Academy of Medical Royal Colleges (AMRC) guidance⁴⁹. The AMRC guidance states that after five minutes of continued cardiorespiratory arrest that one of the measures to confirm death would be a lack of any motor response to supra-orbital pressure. This aspect of the guidance is not universally followed with expected deaths and it would be appropriate to use a trapezius squeeze to assess lack of motor response. This will prevent potential marking of the deceased's face.
24. The professional verifying the death is responsible for confirming the identity of the deceased (where known) using the terminology of 'identified to me as'. This requires name, date of birth, address and NHS number (if known). It is good practice for the person verifying the death to attach name bands with this information to the wrist or ankle of the deceased. The following details are required when reporting a death to the coroner: the professional's telephone/ bleep number; the deceased's name, address, date of birth and GP details; family members' names, contact details and relationship to the deceased; date and time of death; details of the person who pronounced life extinct and details of what happened leading up to the death, including who was present at the time of death.

- 25.** The practitioner who verified the death ascertains whether the person had a known or suspected infection and whether this is notifiable⁵⁰. There is specific guidance for Hazard Group 4 viral haemorrhagic fevers⁵¹. In such cases, they should then follow their local infection control policy regarding reporting responsibilities. It is vital that processes are in place to protect confidentiality, which continues after death. However, this does not prevent the use of sensible rules to safeguard the health and safety of all those who may care for the deceased⁵². There needs to be clear communication regarding infection risk and the presence of implantable devices to mortuary staff and funeral directors. If the deceased had a notifiable infection there is detailed guidance available, including on the infections that require the use of a body bag⁵³.
- 26.** If it is not appropriate or possible to provide personal care after death in the area where the death occurred, eg when the death occurs in theatre or in a scanner, then the deceased should be transferred to the relevant ward area for this care to be given and the deceased should be transferred on a bed with an appropriate cover.
- 27.** If the relatives or carers are not present at the time of death they need to be informed by a professional with appropriate communication skills⁵⁴ and offered support, including access to a healthcare chaplain or other appropriate person.
- 28.** If the case is being referred to the coroner because the cause of death is unknown or the death is unexpected, seek advice before moving or removing anything that might be relevant to establishing the cause of death.
- 29.** When the death is unexpected in a health or social care setting, the health or social care professionals involved in caring for the person when they died need to inform the family face-to-face (whenever possible). They need the necessary communication skills to do this and to ensure there is appropriate support – such as an interpreter service – available where there may be communication barriers. They need to be aware of the physical environment and the needs of any children present. Adults may require guidance on how best to convey the news to children who are not present⁵⁵. If the deceased was living in a care home but died in hospital, inform the home too, because staff may know about the person's wishes around death. The police can be of assistance in locating relatives and breaking significant news. Guidance is available for breaking significant news by phone⁵⁶.
- 30.** It is anticipated that mental health and prison services would have robust policies on unexpected death as all deaths would be referred to the coroner and would need police attendance at an undisturbed scene of death. It is likely in mental health care settings that the police would break the news to family members, and in prison settings that this would occur through the support of the family liaison officer. Likewise it is anticipated that both prison and mental health services will have detailed lists of external agencies to inform, eg the Care Quality Commission.

Care after death

Responsibility

31. In NHS hospitals and private nursing homes the personal care after death is the responsibility of a registered nurse, although this and the packing of the deceased's property may be delegated to a suitably trained healthcare support worker. The registered nurse is responsible for correctly identifying the deceased, being aware of when to refer to the coroner and communicating accurately with the mortuary or funeral director (in line with local policy). In care homes without a registered nurse, the home manager is responsible for ensuring that professional carers are trained appropriately and that they have the relevant competence for the role. In prisons personal care after death is the responsibility of the prison service (not prison healthcare), and all property is left for the family liaison officer to return to the family.

Environment

32. The deceased needs to be cared for with dignity. It is helpful if the surrounding environment conveys this respect. This includes the attitudes and behaviour of staff, particularly as bereaved people can experience high levels of anxiety and/or depression. Evidence suggests that the wider end of life care environment – for example, the journey to the mortuary and how the deceased's possessions are handled – not only has an immediate impact on relatives but also impacts on their subsequent bereavement⁵⁷.

33. The personal care after death needs to be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. It is

important to note that the body's core temperature will take time to lower and therefore refrigeration within four to six hours of death is optimum⁵⁸. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing them and the room for viewing need to be completed as soon as possible within this time. When families cannot view the deceased, for example after death in theatres, make arrangements for viewing at another appropriate location, such as a viewing room attached to a mortuary. In community settings there may be more flexibility for viewing arrangements. In prison settings families will view in an alternative location arranged by the family liaison officer.

34. Residents in communal settings, such as care homes and prisons, have often built significant relationships with other residents and members of staff and they will need to be informed of the death. Consider how to address their need to know of the death within the boundaries of patient confidentiality. If the person has died in an environment where other people may be distressed by the death then inform them sensitively, using relevant resources as appropriate (eg those produced to assist those with learning disabilities⁵⁹), that the person has died, being careful not to provide information about the cause and reason for death. Consider signposting to bereavement support in these settings.

35. Pack personal property, showing consideration for the feelings of those receiving it and in line with local policy. Discuss the issue of soiled clothes sensitively with the family and ask whether they wish them to be disposed of or returned.

36. Provide the family with written information on the processes to be followed after death, including how to collect the MCCD, where to register the death and the role of the funeral director and bereavement support agencies. Be aware of the information available for relatives in their local area and the professional's role in ensuring that written information is given in a supportive way. Offer to guide people through its content and give them the opportunity to ask questions.
37. Record all aspects of care after death in locally relevant documentation and identify the professionals involved⁶⁰. Update and organise the medical and nursing records as quickly as possible so they are available to the bereavement team and other interested professionals, such as pathologists.
38. Notify all other relevant professionals involved in the person's care that the person has died.
39. It is good practice to ensure that, when the death need not be referred to the coroner, the MCCD is issued within one working day so burial or cremation arrangements are not unduly delayed. Cultural or religious practices may require it to be completed on the same day, so organisational processes are needed to address this wherever possible. If cremation is preferred then the appropriate forms and procedures should be completed within two working days.

Viewing the deceased

40. Unless the death is suspicious and needs referring to the coroner and police, let the family sit with their relative if they wish in the period immediately after death. Offer age appropriate support; for example, parents may wish a bereaved child to take a favourite toy to the hospital viewing room/ funeral directors. Even after a traumatic death, relatives need the opportunity to view the deceased and decide which family member, if any, should identify the body. Prepare them for what they might see and explain any legal reasons why the deceased cannot be touched⁶¹. It should be noted that many mortuary staff have advanced skills in reconstruction and bodies may be more acceptable for viewing after post-mortem examination, though relatives need to know that the capacity for such reconstruction will differ greatly from case to case. Discussion with local mortuary staff on this issue can be valuable.
41. On the very few occasions when a death is suspicious or unexplained and a special forensic post-mortem examination is required, the family can only view the deceased with the agreement of the coroner and police. The limitations placed on viewing will depend on the nature of the death. In many cases there will be few restrictions but if the death is regarded as suspicious it will be important not to permit any potential contamination of forensic evidence.

42. Many hospices have cold rooms that offer the family the opportunity to view the deceased beyond the time possible in other environments. In this facility the room temperature needs to be kept below 12 degrees centigrade and preferably between four to eight degrees centigrade. This may not be tolerable for relatives who wish to be in the room for extended periods and there are now cold beds and blankets that can offer effective cooling systems. Whilst each case can be determined on its own merit, if viewing is required beyond three days after death then expert advice should be sought from the mortuary staff or funeral director, due to the natural deterioration of the body that takes place after this time.

Personal care after death

Deaths requiring coronial involvement

43. If the death is being referred to the coroner, there is a complaint about the care of the patient, or the circumstances surrounding the death give rise to suspicion that means the death requires forensic investigation, leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact (this includes syringe drivers with controlled drugs). Leave any catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case it destroys evidence. Continue using universal infection measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death.
44. Where the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave intravenous cannulae and lines in situ and catheters spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy.
45. Leave endotracheal (ET) tubes in situ. This is because cutting the tube deflates the balloon that holds the tube in position. The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through post-mortem examination.

46. Sensitively inform the family that, after the coroner's involvement, ET tubes or lines will be removed and they will then be able to spend time with the deceased. They can also do this at the funeral director's premises.
47. Personal care can then be given as per deaths without coronial involvement.

Deaths without coronial involvement

48. Some family members/carers may wish to assist with the personal care. Prepare them sensitively for changes to the body after death and be aware of manual handling and infection control issues.
49. Carry out all personal care of the deceased after death in accordance with safe manual handling guidance. It is best practice to do this with two people, one of whom needs to be a registered nurse or a suitably trained person.
50. Lay the deceased on their back, adhering to manual handling policy; straighten their limbs (if possible) with their arms lying by their sides. Leave one pillow under the head as it supports alignment and helps the mouth stay closed. If it is not possible to lay the deceased flat due to a medical condition then seek guidance from the mortuary staff or funeral director. In addition, the mortuary and porters should be alerted if the deceased is bariatric so that they have the appropriate equipment to transfer the deceased.

51. Close the eyes only by applying light pressure for 30 seconds (this applies too if the deceased is donating their corneas⁶²). If this fails then explain sensitively to the family/carers that the funeral director will resolve the issue.
52. Clean the mouth to remove debris and secretions. Clean and replace dentures as soon as possible after death. If they cannot be replaced send them with the deceased in a clearly identified receptacle.
53. Tidy the hair as soon as possible after death and arrange into the preferred style (if known) to guide the funeral director for final presentation.
54. Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later. Usually the funeral director will do this. If the family/carers request it earlier then sensitively discuss the consequences and document this in the notes. Be aware that some faith groups prohibit shaving.
55. Support the jaw by placing a pillow or rolled up towel underneath (remove it before the family/carers view the person). Avoid binding with bandages to close the mouth as this can leave pressure marks on the face. Some people have jaws that will never close – notify the mortuary staff or funeral director if this is the case.
56. When the death is not being referred to the coroner remove mechanical aids, such as syringe drivers, apply gauze and tape to syringe driver sites and document disposal of medication.
57. Do not tie the penis. Do spigot any urinary catheters. Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum.
58. Contain leakages from the oral cavity or tracheostomy sites by suctioning and positioning. Suction and spigot nasogastric tubes. Cover exuding wounds or unhealed surgical incisions with a clean, absorbent dressing and secure with an occlusive dressing. Leave stitches and clips intact. Cover stomas with a clean bag. Clamp drains (remove the bottles), pad around wounds and seal with an occlusive dressing. Avoid waterproof, strongly adhesive tape as this can be difficult to remove at the funeral directors and can leave a permanent mark. Cap intravenous lines and leave them in situ. If the body is leaking profusely then take time, pre transfer to the mortuary, to address the problem. Ensure mortuary staff and funeral directors are informed of any potential for profuse leakage to enable appropriate positioning of the deceased in the refrigeration areas.
59. Mortuary staff should discuss with the funeral director collecting the deceased their ability to remove intravenous lines, drains, indwelling catheters, etc. If they are unable to remove these then the mortuary technician should attend to this before releasing the deceased. When a family member collects the deceased all lines should be removed unless there is a risk of leakage which may cause more distress. When release to a funeral director is prompt in order to ensure same day burial the funeral director should ensure that all lines are removed in case family members wish to bathe or dress the deceased.

60. Clean and dress the deceased appropriately before they go to the mortuary. The use of shrouds is commonplace in many acute hospitals. The deceased should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary. Be aware that soiling can occur. The funeral director will dress the deceased in their own clothes. In community settings the district or community nurse may offer to do this, and in some instances the family may want to do it themselves. If this is the case they need to be advised sensitively on how to deal with soiling.
61. Remove jewellery (apart from the wedding ring) in the presence of another member of staff, unless specifically requested by the family to do otherwise, and document this according to local policy. Be aware of religious ornaments that need to remain with the deceased. Secure any rings left on with minimal tape, documented according to local policy. Provide a signature if any jewellery is removed. Procedures are needed to account for this information to onward caregivers.
62. Clearly identify the deceased with a name band on their wrist or ankle (avoid toe tags). As a minimum this needs to identify their name, date of birth, address, ward (if a hospital in-patient) and ideally their NHS number. The person responsible for identification is the person that verifies the death.
63. Provided no leakage is expected and there is no notifiable disease present, the deceased can be wrapped in a sheet and taped lightly to ensure it can be moved safely. Do not bind the sheet or tape too tightly as this can cause disfigurement. If there is significant leakage or if a notifiable infection is present put the deceased into a body bag⁶³.
64. If the body continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director.
65. Request removal of the deceased. In hospital settings it is best practice for porters to take the deceased from the ward to the mortuary within one hour of request so it can be refrigerated within four hours of death⁶⁴. This ensures that tissue donation can take place (if requested) and prevents distress to surrounding patients. In hospital settings the deceased are released via the mortuary. In hospice settings the deceased should be moved to the chilled room within two to four hours.

Transfer of the deceased

66. The privacy and dignity of the deceased on transfer from the place of death is paramount⁶⁵. Each organisation involved is responsible for ensuring that the procedures adopted to transfer bodies respect the values of personal dignity, and that these are incorporated in the design of the concealment trolley and the way the deceased is covered. Place the deceased in an appropriate container to avoid causing distress to others, for example, the deceased may be transferred in a bed with an appropriate cover. It is not recommended to transfer the deceased in ways that make them appear as alive to others, eg with an oxygen mask in situ. In community settings a funeral director will usually undertake transfer, although case law has determined that the deceased's executor (generally a family member) may also do this⁶⁶.
67. Follow standard infection control precautions during transfer and remove gloves when moving the deceased along corridors, as there is no risk of infection once the deceased is placed on the trolley. Try to retain a sense of the person's dignity in transit, avoiding busy public spaces if possible. Hospital porters may need training on this issue.
68. If the family are using a viewing room alongside a mortuary it is good practice for registered nurses to help them find it, ensure mortuary staff know to expect them and, if necessary, arrange for the family to be accompanied. In many acute hospitals bereavement teams provide the primary support for families⁶⁷.

Education, training and support of staff providing care after death

69. Education and training on all aspects of care after death should be included in all relevant pre-registration training curricula – particularly for medicine, nursing, and social care. All aspects of this care should be included in training for funeral directors.
70. The pertinent aspects of care after death, for the relevant staff, should be included in induction and mandatory training programmes, eg for doctors this should include teaching about verification of death; writing of MCCD's; consent provisions of the Human Tissue Act with regard to post-mortem examination and tissue retention; organ and tissue donation and the coronial system. For nurses it should include identification, who should be referred to the coroner, and personal care after death. For porters it should include safe handling and transfer and preparation for transferring the dying. For all staff it should include communication and documentation.
71. All organisations should consider the training requirements of appropriate staff to ensure the verification of death occurs in a timely manner.
72. The opportunity for debriefing should be available for staff after a death⁶⁸. In places of care where deaths happen frequently, eg acute hospital trusts, debriefing may take place after exceptionally challenging deaths or when the cumulative effect of many deaths is recognised.
73. All incidents related to care after death should be accounted for within the local organisation for local action / governance with cascade up according to the seriousness and widespread applicability of any learning points or actions. Serious incidents that take place in a mortuary setting must be reported to the Human Tissue Authority (HTA)⁶⁹. All staff working in the mortuary should be aware of the reporting requirements, and this should be addressed in training.

References

- ¹ *Guidance for staff responsible for care after death (last offices)*. National End of Life Programme and National Nurse Consultant Group (Palliative Care) (2011). http://www.nhs.uk/nhs.uk/media/2426968/care_after_death___guidance.pdf (accessed 17 March 2015).
- ² *Evaluation of Care After Death Programme*. Institute of Healthcare Management (2013). <http://www.ihm.org.uk/en/news-and-policy/projects/Supporting-National-and-Local-End-of-Life-Care-Work/evaluation-of-care-after-death-programme.cfm> (accessed 17 March 2015).
- ³ *A guide to end of life care: care of children and young people before death, at the time of death and after death*. Together for Short Lives (2012). http://www.togetherforshortlives.org.uk/assets/0000/1855/TfSL_A_Guide_to_End_of_Life_Care_5_FINAL_VERSION.pdf (accessed 17 March 2015).
- ⁴ *Code of practice 1 - Consent*. Human Tissue Authority (2014). http://www.hta.gov.uk/legislationpoliciesandcodesofpractice/codesofpractice/code1consent.cfm?FaArea1=customwidgets.content_view_1&cit_id=666&cit_parent_cit_id=652 (accessed 17 March 2015).
- ⁵ Jones J, Hunter D (1995). Consensus methods for medical and health services research. *British Medical Journal*; vol 311, issue 7001, pp 376-80.
- ⁶ *A code of practice for the diagnosis and confirmation of death*. Academy of Medical Royal Colleges (2008). http://www.aomrc.org.uk/doc_view/42-a-code-of-practice-for-the-diagnosis-and-confirmation-of-death (accessed 17 March 2015).
- ⁷ *One chance to get it right: improving people's experience of care in the last few days and hours of life*. Leadership Alliance for the Care of Dying People (2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf (accessed 17 March 2015).
- ⁸ Sque M, Walker W, Long-Sutehall T, Morgan M, Randhawa G, Warrens A (2013). *Bereaved families' experiences of organ and tissue donation, and perceived influences on their decision making. Final report of a study funded by the Department of Health*. University of Wolverhampton.
- ⁹ *Safety in custody statistics England and Wales update to December 2012*. Ministry of Justice (2012). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192431/safety-custody-dec-2012.pdf (accessed 17 March 2015).
- ¹⁰ Personal communication – Andy Pring 2014 Public Health England – cancer and end of life intelligence analyst.
- ¹¹ Turner M, Payen S, Barbarachild Z (2011). Care or custody? An evaluation of palliative care in prisons in NW England. *Palliative Medicine*; 25(4): 370-377.
- ¹² *The routes to success in end of life care – achieving quality in prisons and for prisoners*. NHS Improving Quality (2014). <http://www.nhs.uk/resource-search/publications/eolc-rts-prisoners.aspx> (accessed 17 March 2015).
- ¹³ *Macmillan adapted prison standards for palliative and end of life care*. Durham and Darlington Foundation Trust (2011).
- ¹⁴ Hollins S, Dowling S, Blackman N (2014). *When somebody dies*. London: Books Beyond Words.

- ¹⁵ Green J, Green M. *Dealing with death: a handbook of practices, procedures and law (second edition)* (2006). London: Jessica Kingsley Publishers.
- ¹⁶ *Coroners and burials statistics*. Ministry of Justice (2014). <https://www.gov.uk/government/collections/coroners-and-burials-statistics> (accessed 17 March 2015).
- ¹⁷ *Deaths of detained patients: Statutory Notification Regulation 17, Care Quality Commission (Registration) Regulations* (2009). <http://www.cqc.org.uk/content/mental-health-notifications> (accessed 17 March 2015).
- ¹⁸ *Statement of government policy on adult safeguarding*. Department of Health (2013). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197402/Statement_of_Gov_Policy.pdf (accessed 17 March 2015).
- ¹⁹ *Treatment and care towards the end of life: good practice in decision making*. General Medical Council (2010). http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp (accessed 17 March 2015).
- ²⁰ *One chance to get it right: Improving people's experience of care in the last few days and hours of life*. Leadership Alliance for the Care of Dying People (2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf (accessed 17 March 2015).
- ²¹ *Consent guidance: patients and doctors making decisions together*. General Medical Council (2008). http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp (accessed 17 March 2015).
- ²² *End of life care for adults in the emergency department*. The Royal College of Emergency Medicine (2015). <http://secure.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/College%20Guidelines> (accessed 17 March 2015).
- ²³ Fletcher AJ, Payne S, Waterman D, Turner M (2013). Palliative and end of life care in prisons in England and Wales: do inequalities exist? A survey of healthcare managers. *BMJ Supportive and Palliative Care*; 3:125.
- ²⁴ *Early release on compassionate grounds in Parole, release and recall* (Prison Service Order 6000). HM Prison Service (2005). <https://www.justice.gov.uk/downloads/offenders/psipso/pso/pso-6000.pdf> (accessed 17 March 2015).
- ²⁵ *A joint statement from the British Medical Association, the Resuscitation Council UK and the Royal College of Nursing* (2007). *Decisions related to cardiopulmonary resuscitation*. <http://www.resus.org.uk/pages/dnar.pdf> (accessed 17 March 2015).
- ²⁶ *The AMBER care bundle*. Guy's and St Thomas' NHS Foundation Trust (2014). <http://www.ambercarebundle.org/homepage.aspx> (accessed 17 March 2015).
- ²⁷ *Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation*. NICE (2011). <https://www.nice.org.uk/guidance/cg135/chapter/person-centred-care> (accessed 17 March 2015).
- ²⁸ *ICD deactivation at the end of life: principles and practice*. British Heart Foundation (2013). <https://www.bhf.org.uk/publications/living-with-a-heart-condition/icd-deactivation-at-the-end-life> (accessed 17 March 2015).

- ²⁹ Gomes B, Higginson IJ (2006). Factors influencing death at home in terminally ill patients with cancer: systematic review. *British Medical Journal*; 332:515.
- ³⁰ *Planning for your future care*. National End of Life Care Programme, Dying Matters, University Of Nottingham (2014). <http://www.ncpc.org.uk/publication/planning-your-future-care> (accessed 17 March 2015).
- ³¹ *An unnatural death – a report into investigations of mesothelioma death and their impact on bereaved families*. British Lung Foundation (2007). <http://www.blf.org.uk/Page/Special-Reports> (accessed 17 March 2015).
- ³² Support after death: practical help when someone dies. Department for Work and Pensions (2013). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254937/dwp004.pdf (accessed 17 March 2015).
- ³³ *Coping with bereavement*. NHS Choices (2014). <http://www.nhs.uk/livewell/bereavement/pages/coping-with-bereavement.aspx> (accessed 17 March 2015).
- ³⁴ *Child death reviews: year ending 31 March 2013*. Department of Education (2013). <https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2013> (accessed 17 March 2015).
- ³⁵ *Sharing learning: lessons learned from HTA reportable incidents in the post mortem sector 2012-2013*. Human Tissue Authority (2013). http://archive.hta.gov.uk/_db/_documents/HTARI_Review_2012-13.pdf (accessed 17 March 2015).
- ³⁶ *The Cremation (England and Wales) Regulations 2008: guidance to medical practitioners completing forms Cremation 4 and 5*. Ministry of Justice (2012). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/325750/cremation-doctors-guidance.pdf (accessed 17 March 2015).
- ³⁷ *Body donation FAQs*. Human Tissue Authority. <https://www.hta.gov.uk/faqs/body-donation-faqs> NICE Clinical Guideline 135. (accessed 17 March 2015).
- ³⁸ *Organ donation for transplantation: improving donor identification and consent rates for deceased organ donation*. NICE guideline CG135 (2011). <https://www.nice.org.uk/guidance/cg135> (accessed 17 March 2015).
- ³⁹ *Code of practice 1 - Consent*. Human Tissue Authority (2014). https://www.hta.gov.uk/code-practice-1-consent?FaArea1=customwidgets.content_view_1&cit_id=666&cit_parent_cit_id=652 (accessed 17 March 2015).
- ⁴⁰ Organ donation contact details. NHS Blood and Transplant. http://www.organdonation.nhs.uk/contact_us/ (accessed 17 March 2015).
- ⁴¹ *Prisons*. Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee <http://www.transfusionguidelines.org.uk/dsg/ctd/guidelines/pr011-prisons?search=p> (accessed 17 March 2015).
- ⁴² Tissue donation contact details. NHS Blood and Transplant. <http://www.nhsbt.nhs.uk/tissuedonation/contact-us/> (accessed 17 March 2015).

- ⁴³ *Flying home or on holiday*. Help the Hospices [now Hospice UK] (2009).
- ⁴⁴ *Improving environments for care at the end of life*. Kings Fund (2008). <http://www.kingsfund.org.uk/sites/files/kf/improving-environments-care-at-end-of-life-eight-uk-pilot-sites-waller-dewar-masterson-finn-april-2008.pdf> (accessed 17 March 2015).
- ⁴⁵ Shelvington et al (2007). *The effect of witnessing death: nursing implications*. <http://www.nursingtimes.net/Journals/2013/02/12/k/t/m/070828THE-EFFECT-OF-WITNESSING-DEATH--1--NURSING-IMPLICATIONS.pdf> (accessed 17 March 2015).
- ⁴⁶ *The Cremation (England and Wales) Regulations 2008: guidance for applicants*. Ministry of Justice (2012). <https://www.gov.uk/government/publications/cremation-guidance-for-applicants> (accessed 17 March 2015).
- ⁴⁷ *Confirmation of death for registered nurses*. Nursing & Midwifery Council (2012).
- ⁴⁸ *GP Mythbuster 13: Who can diagnose death?* Care Quality Commission (2014). <http://www.cqc.org.uk/content/gp-mythbuster-13-who-can-diagnose-death> (accessed 17 March 2015).
- ⁴⁹ *A code of practice for the diagnosis and confirmation of death*. Academy of Royal Medical Colleges (2008). http://www.aomrc.org.uk/doc_view/42-a-code-of-practice-for-the-diagnosis-and-confirmation-of-death (accessed 17 March 2015).
- ⁵⁰ *Controlling the risks of infection at work from human remains*. Health and Safety Executive (2005). <http://www.hse.gov.uk/pubns/web01.pdf> (accessed 17 March 2015).
- ⁵¹ *Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence*. Department of Health (2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377143/VHF_guidance_document_updated_19112014.pdf (accessed 17 March 2015).
- ⁵² *Confidentiality: disclosing information about serious communicable diseases*. General Medical Council (2009). http://www.gmc-uk.org/Confidentiality_disclosing_info_serious_commun_diseases_2009.pdf_27493404.pdf (accessed 17 March 2015).
- ⁵³ *Controlling the risks of infection at work from human remains*. Health and Safety Executive (2005). <http://www.hse.gov.uk/pubns/web01.pdf> (accessed 17 March 2015).
- ⁵⁴ *Common core principles and competences for social care and health workers working with adults at the end of life*. Skills for Care (2014). <http://www.skillsforcare.org.uk/Document-library/Skills/End-of-life-care/Common%20core%20principles%20and%20competences%20for%20social%20care%20and%20health%20workers%20working%20with%20adults%20at%20the%20end%20of%20life.pdf> (accessed 17 March 2015).
- ⁵⁵ *Breaking bad news to children – information for staff*. Child Bereavement UK (2011). http://www.childbereavementuk.org/files/3514/0144/2856/Breaking_bad_news_to_children.pdf (accessed 17 March 2015).
- ⁵⁶ Taylor E (2007). How best to communicate bad news over the telephone. *End of Life Care*; 1(1):30-37.

- ⁵⁷ *Improving environments for care at the end of life*. Kings Fund (2008). <http://www.kingsfund.org/sites/files/kf/improving-environments-care-at-end-of-life-eight-uk-pilot-sites-waller-dewar-masterson-finn-april-2008.pdf> (accessed 17 March 2015).
- ⁵⁸ *Retrieval*. Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee <http://www.transfusionguidelines.org.uk/red-book/chapter-21-tissue-banking-tissue-retrieval-and-processing/21-2-retrieval> (accessed 17 March 2015).
- ⁵⁹ *Palliative care, end of life care and bereavement (for people with learning disabilities)*. Change. <http://be.macmillan.org.uk/be/p-19441-palliative-care-end-of-life-care-and-bereavement-for-people-with-learning-disabilities.aspx> (accessed 17 March 2015).
- ⁶⁰ *The code: standards of conduct, performance and ethics for nurses and midwives*. Nursing & Midwifery Council (2008).
- ⁶¹ Chapple A, Ziebland S (2010). Viewing the body after bereavement due to traumatic death: qualitative study in the UK. *British Medical Journal*; Apr 30;340:c2032.
- ⁶² April (2012) Personal communication from NHSBT.
- ⁶³ *Controlling the risks of infection at work from human remains*. Health and Safety Executive (2005). <http://www.hse.gov.uk/pubns/web01.pdf> (accessed 17 March 2015).
- ⁶⁴ *Retrieval*. Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee <http://www.transfusionguidelines.org.uk/red-book/chapter-21-tissue-banking-tissue-retrieval-and-processing/21-2-retrieval> (accessed 17 March 2015).
- ⁶⁵ *Improving environments for care at the end of life*. Kings Fund (2008). <http://www.kingsfund.org/sites/files/kf/improving-environments-care-at-end-of-life-eight-uk-pilot-sites-waller-dewar-masterson-finn-april-2008.pdf> (accessed 17 March 2015).
- ⁶⁶ Russell Davies MR (2002). *Davies' law of burial, cremation and exhumation* (7th edition). Shaw & Sons Ltd.
- ⁶⁷ Green M. (2013). *An investigation into the development of bereavement care services within the acute NHS sector in England*. MSc Dissertation unpublished.
- ⁶⁸ Hockley J (2014). Learning, support and communication for staff in care homes: outcomes of reflective debriefing groups in two care homes to enhance end of life care. *The International Journal for Older People Nursing*; 2014; 9(2):118-30.
- ⁶⁹ *Guidance for reporting HTA Reportable Incidents (HTARIs) in the post mortem sector*. Human Tissue Authority (2013). <https://www.hta.gov.uk/policies/post-mortem-hta-reportable-incidents> (accessed 17 March 2015).

Glossary

Cardiac defibrillator – a device that delivers a therapeutic dose of electrical energy to a heart affected by arrhythmia.

Cold room – a room chilled to preserve the body, enabling family/carers to spend extended amounts of time with the deceased. Usually located in hospices.

Endotracheal (ET) tube – a catheter that is inserted into the trachea to establish/maintain the airway and ensure the adequate exchange of oxygen and carbon dioxide.

Medical certificate of the cause of death (MCCD) – a document given to families to enable them to register the death and gain the death certificate.

Suspicious death – one where crime is suspected, where an accident has occurred, when death conflicts with the medical prognosis or when a death occurs because of trauma in a medical setting.

Appendix 1: Deaths requiring coronial investigations

A death should be reported to the coroner when:

- the cause of death is unknown
- there is no attending practitioner(s) or the attending practitioner(s) are unavailable within a prescribed period
- the death may have been caused by violence, trauma or physical injury, whether intentional or otherwise
- the death may have been caused by poisoning
- the death may be the result of intentional self harm
- the death may be a result of neglect or failure of care
- the death may be related to a medical procedure or treatment
- the death may be due to an injury or disease received in the course of employment, or industrial poisoning
- the death occurred while the deceased was in custody or state detention, whatever the cause of death.

More detailed information is available from the Ministry of Justice publication *A guide to coroners and inquests* (2010).

Appendix 2: Information required by mortuary staff and funeral directors

A new form is to be created to communicate information about the deceased to mortuary staff and funeral directors.

Until then local policies should ensure that the following information is generated from the place of death and provided to mortuary staff and funeral directors:

- Identifying information including name, date of birth, address and NHS number (if known)
- Date and time of death
- Implantable devices
- Current radioactive treatments
- Notifiable infections
- Any jewellery or religious mementoes left on the deceased
- Name and signature of registered nurse responsible for the care after death
- Name and signature of any second healthcare professional who assisted with care

Appendix 3: Key stakeholders involved in the development of this guidance

All organisations that were involved in the first edition of the guidance were invited to take part in the production of the second edition and have been fully consulted.

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Professional Networks

Benchmarking Intelligence

Income ehospice Events

International Publications

Families Governance

Donate

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