

# VERIFICATION OF DEATH OF ADULT PATIENTS BY REGISTERED NURSES AND ALLIED HEALTH PROFESSIONALS

## Policy

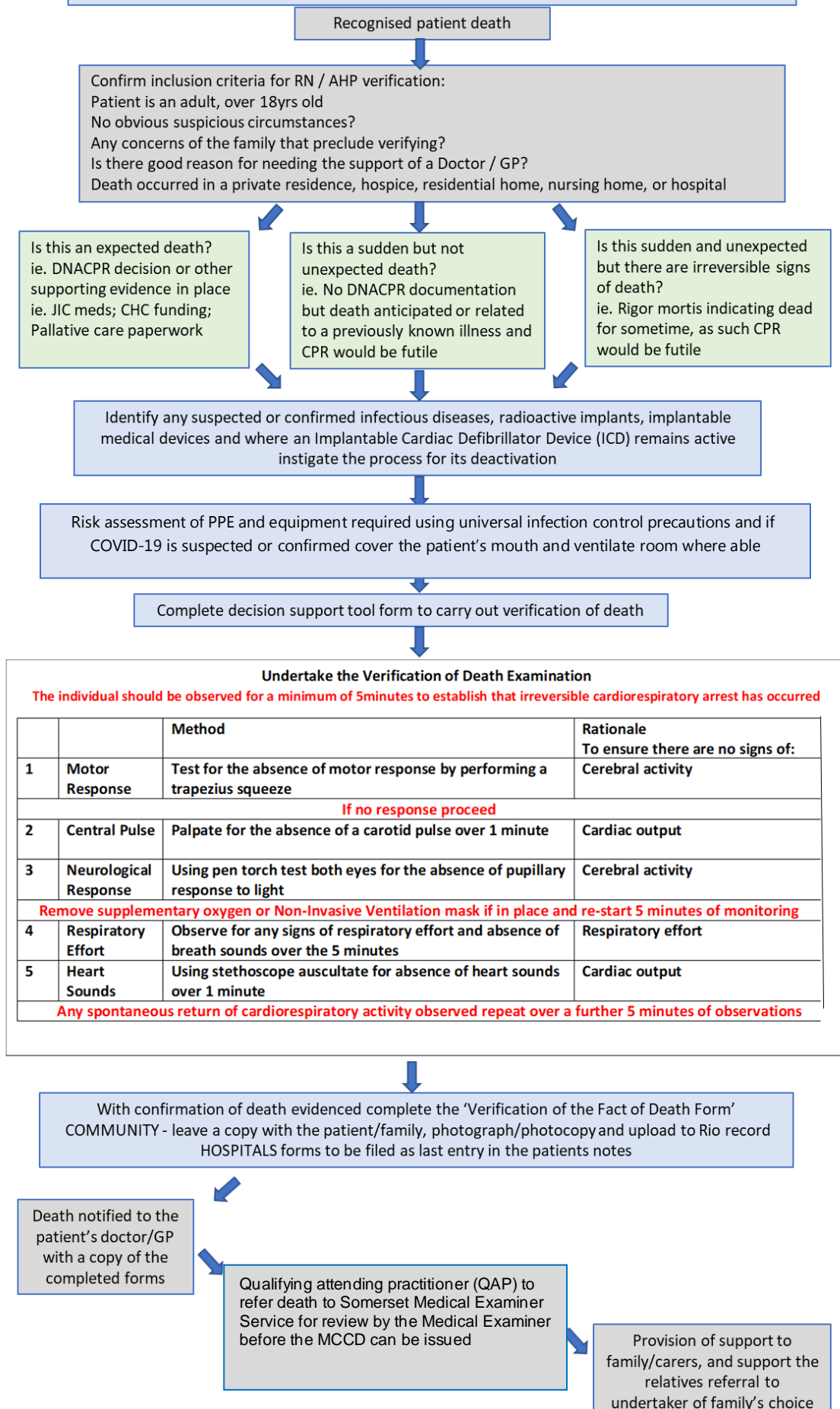
This document can only be considered current when viewed via the current document directories / systems. If this document is printed or saved to another location, you are advised to check that the version you use remains current and valid, with reference to the 'review due' date.

<b>Version Number:</b>	9	<b>Issue date:</b>	13/06/24 Minor amendment 03/02/2025	<b>Next review due:</b>	13/06/27
<b>Author(s):</b> <b>Name(s) &amp; Job Title(s)</b>	Catherine Leask, Palliative Care Consultant Emma King Trainee Advanced Clinical Practitioner in District Nursing				
<b>Owner:</b>	Catherine Leask, Palliative Care Consultant				
<b>Approved by:</b>	End of Life Programme Board				
<b>Approval date:</b>	07/02/2024				
<b>Colleagues / Groups Consulted:</b>	Dr Charlie Davies – Associate Medical Director Neighbourhoods and Primary Care, Palliative Medicine Consultant Mary Martin – Professional Lead Community Nursing Helen Waldon - Implementation Lead – Somerset Medical Examiner Service, Head of Bereavement & Medical Examiner Services SFT Anna Saunders Senior Sister, St Margaret's Hospice Sarah Ireland – Education Lead for St Margaret's Hospice Laura James – End of Life Care Education Lead Sarah Copp – Clinical Palliative Care Nurse Specialist Sharon Stone – Senior Sister Community Hospitals Martyn Strawbridge and Jacqui Kemp - Arrhythmia Nurse Specialists Musgrove Park Rob Lutyens – Nurse Consultant, Yeovil District Hospital Liz Berry – Clinical Skills Lead				

# CONTENTS

<b>1.0</b>	<b>FLOW CHART / KEY STEPS QUICK REFERENCE SUMMARY</b>	<b>3</b>
<b>2.0</b>	<b>INTRODUCTION</b>	<b>4</b>
<b>3.0</b>	<b>PURPOSE AND SCOPE</b>	<b>4</b>
<b>4.0</b>	<b>ROLES and RESPONSIBILITIES</b>	<b>4</b>
<b>5.0</b>	<b>DEFINITIONS / EXPLANATION OF TERMS USED</b>	<b>5</b>
<b>6.0</b>	<b>LEGAL POSITION</b>	<b>6</b>
<b>7.0</b>	<b>VERIFICATION OF DEATH INCLUSION AND RESPONSIBILITIES</b>	<b>7</b>
<b>8.0</b>	<b>EXCEPTIONS TO VERIFYING DEATH</b>	<b>9</b>
<b>9.0</b>	<b>NOTIFYING THE CORONER</b>	<b>10</b>
<b>10.0</b>	<b>VERIFICATION OF DEATH EXAMINATION</b>	<b>10</b>
<b>11.0</b>	<b>TRAINING / COMPETENCE REQUIREMENTS</b>	<b>11</b>
<b>12.0</b>	<b>MONITORING COMPLIANCE AND EFFECTIVENESS</b>	<b>11</b>
<b>13.0</b>	<b>REFERENCES</b>	<b>12</b>
<b>14.0</b>	<b>Cross reference to other documents</b>	<b>13</b>
<b>15.0</b>	<b>Appendix A</b> Verification of Death Decision Support Tool	<b>15</b>
<b>16.0</b>	<b>Appendix B</b> Verification of Fact of Death Form	<b>16</b>
<b>17.0</b>	<b>Appendix C</b> Procedure for completing and submitting the CQC form: 'Statutory notification about the death of a person detained or liable to be detained under the Mental Health Act 1983'	<b>17</b>
<b>18.0</b>	<b>Appendix D</b> Reference guide for GPs regarding inclusion / exclusion criteria for RN/AHP verification of death	<b>18</b>
<b>19.0</b>	<b>Appendix E</b> Learning contract and Competencies	<b>19</b>
<b>20.0</b>	<b>Appendix F</b> Deactivation of ICD Pathway	<b>25</b>
<b>21.0</b>	<b>Appendix G</b> Implantable Device Notification Form	<b>26</b>
<b>22.0</b>	<b>Appendix H</b> NOTIFICATION OF AN IMPLANTABLE MEDICAL DEVICE	<b>27</b>
<b>23.0</b>	<b>Appendix J</b> Audit Standards	<b>28</b>

# Flowchart for verification of death



## 2.0 INTRODUCTION

- 2.1 This document provides a framework for the verification of death by Registered Nurses (RNs) and Allied Health professionals (AHPs). A large percentage of a nurse's time is spent caring for patients who are terminally ill. Death is inevitable for all living beings and, as health care providers, nurses play a principle role in the care of dying individuals and their families. The ability of the RN/AHP to confirm the expected death of a patient and provide aftercare to relatives and carer's will provide continuity of care at a time of anxiety and distress.
- 2.2 If the RN/AHP has any concerns that the death may not be from natural causes this must be reported immediately. This will be a discussion with their line manager/doctor/GP who can discuss any issue with a coroner's officer. In the community setting out of hours the police will need to be contacted in their role as deputising for the coroner's office.
- 2.3 If a RN/AHP does not feel confident in their competence to verify death after completing training, they could undertake the verification of death with the remote support and guidance of a more experienced colleague.
- 2.4 A RN/AHP must be trained and competent to confirm the death and there must be an explicit local policy in place which the healthcare professional must check for specific details.

## 3.0 PURPOSE AND SCOPE

- 3.1 The expected outcomes for this policy are as follows:
- For the death of the patient to be dealt with in a timely, sensitive and caring manner
  - Death to be dealt with in line with the law and coroner requirements
  - Respecting dignity, religious and cultural needs of the patient and family members as is practicable
  - Ensuring the health and safety of others, e.g. from infectious illness including COVID-19, radioactive implants and implantable devices
  - Removal of devices prior to verification of death is illegal
  - RN and AHP's skills and competencies are used appropriately
  - Distress of relatives is minimised

## 4.0 ROLES AND RESPONSIBILITIES

- 4.1 The **Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate.
- 4.2 **The Chief Nurse** will oversee the delegation for implementation of this policy.
- 4.3 **Matrons and service leads** are responsible for ensuring that staff are aware of the policy and that any staff training needs are identified and addressed.

- 4.4 **All relevant Staff** are responsible for adhering to the policy which provides a framework for best practice.

## 5.0 DEFINITIONS / EXPLANATION OF TERMS USED

- 5.1 **Expected death** can be defined as death following a period of naturally occurring terminal illness. It is anticipated, expected and predicted.
- 5.2 **Sudden but not unexpected death** to encompass those situations where patient death has occurred and for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded.
- 5.3 **Irreversible death** in cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis where the patient has evidently been dead for some time. In such circumstances, the patient may not have a DNACPR decision in place but where CPR would be physiologically futile and unsuccessful it should not be performed, as indicated in the resus council guidelines.
- 5.4 **Verification of the fact of death** is defined as confirming whether a patient is actually deceased and documenting the death formally in line with national guidance, it is required before the body can be moved. NB. The time of verification is recognised as the official time of death. Official time and date of death therefore if the patient dies before midnight but is not verified until after midnight, the date of death on the paperwork will be the date of verification. Families should be advised that there might be a difference between the time of the last breath and the official time of death.
- 5.5 **Timely verification** within one hour in a hospital setting and within four hours in a community setting. With recognition that this timeframe may not be achievable, in these cases it may be appropriate to offer guidance to families regarding positioning of the deceased person and the maintenance of a cool environment.
- 5.6 **Recognition of death**, relatives, care home staff and others can recognise that death has occurred, formal verification of death is then required to identify the patient is actually deceased, this is a legal requirement before the body can be moved and certification can be made.
- 5.7 **Certification of death** is the process of completing the 'Medical Certificate of the Cause of Death' (MCCD) by a Qualifying Attending Practitioner.
- 5.8 Do not attempt cardio-pulmonary resuscitation (DNACPR) Advanced decision not to attempt Cardiopulmonary Resuscitation (CPR) - the medical treatment that endeavours to restart cardio-respiratory function in order to allow a natural death.

## 6.0 LEGAL POSITION

### 6.1 English law at present

- does **not** require a doctor to confirm that death has occurred or that “life is extinct”. There are exceptions to this, please refer to section 8 of this policy.
- does require the QAP to have seen the deceased in their lifetime and know to the best of their knowledge and belief why that person has died.
- does require a referral to the coroner if there is no QAP able to provide a cause of death or available in an acceptable period of time.

6.2 Certification of death is a process completed by a General Medical Council (GMC) registered Qualifying Attending Practitioner (QAP).

6.3 Best practice is that all deaths should be subject to professional verification.

6.4 The Royal College of Nursing states ‘experienced registered nurses have the authority to confirm death, notify the relatives, and arrange for care after death and the removal of the body to the mortuary or the appropriate funeral parlour’.

6.5 A RN/AHP can verify the natural death of a person subject to the Mental Health Act 1983 (see Appendix C for a list of relevant sections). The team must report the death of a person subject to the Mental Health Act to the Care Quality Commission (CQC) within three days of the death. This applies to both the neighbourhoods and community services and the Mental Health and Learning Disabilities service groups.

6.6 A RN/AHP may also verify the natural death of a person subject to an urgent or standard authorisation under the Deprivation of Liberty Safeguards.

6.7 Deaths where an industrial related disease is likely to be a cause can be verified by a RN/AHP working under the framework of this policy. An example of this would be mesothelioma. No special treatment of the body is required (in line with any infection control needs) and a person can be moved to by a funeral director or to a cold room/mortuary.

### 6.8 Medical Certificate of the Cause of Death (MCCD)

All deaths in England & Wales must have an independent review by either HM Coroner or a Medical Examiner, without exception.

- If the GMC registered QAP who attended the person before death is unavailable, another doctor can sign the medical certificate of cause of death (MCCD) for all natural deaths, if they have seen them in their lifetime and are able to provide a cause of death to the best of their knowledge or belief. For deaths with a known cause of death and is not reportable to HM Coroner, a referral should be made directly to SMES. For deaths where there is a known cause of death but is notifiable to HMC, the coroners Electronic Death Reporting Form can be completed and sent to SMES by way of referral instead of the SMES referral form. For deaths with an unknown cause, the EDRF

should be completed and sent directly to HMC.

- This will only be once the QAP has made a referral to Somerset Medical Examiner Service with a proposed cause of death, which is reviewed and agreed by the Medical Examiner.
- There is a requirement for the deceased to have been seen by a doctor in their lifetime. Seen by must be in clinical consultation, in person or by video link are allowable in this context, but phone consultations are not.
- The coroner will not accept the 'seen by' practitioner as anyone other than a GMC registered doctor.
- The same MCCD form will be used and amended as necessary.

6.9 **Covid-19** The coronavirus (emergency) Act 2020 was withdrawn March 2022 however ongoing:

- A person suspected of, or confirmed with, COVID-19 at the time of death is not a reason on its own to refer the death to the coroner.
- Diagnosis of suspected (or confirmed) COVID-19 is a notifiable infectious disease and must be reported by the medical registered practitioner to the Health Protection team at the time of suspected diagnosis.

6.10 **Registration of Death** Registration offices were closed during covid, they are now open for face-to-face appointments only and registration should be carried out within 5 days on receipt of the completed MCCD by Somerset Registrations.

- Certificates should be sent electronically to the secure local Medical Examiner email address to allow the form to be checked and countersigned by the ME, before it is then forwarded to Somerset Registrations.
- Hardcopies should have the information "MCCD, Surname, Forename, Date of Death" on each page in case they should become separated. ±
- Relatives should be asked to ring 01823 282251 (number for the whole of Somerset) to make a face-to-face appointment with the registrar to complete the registration process, telephone appointments are no longer available. Families are however able to register by declaration when they are unable to travel to Somerset, they can contact their local registration office, and it can be arranged with Somerset via them.

## 7.0 VERIFICATION OF EXPECTED DEATH CRITERIA AND RESPONSIBILITIES

7.1 **Inclusion criteria:** For all RNs/AHPs, trained and competent, working within their care setting to verify the death of all adults (over the age of 18) and where the following conditions apply:

- Not accompanied by any suspicious circumstances.
- Death is expected, evidenced by supporting information i.e. DNACPR decision.
- Or where death is sudden yet not unexpected, where for whom attempting CPR

is clearly inappropriate i.e. a person in the advanced stages of a terminal illness where death is unavoidable and CPR would not be successful, but for whom no formal DNACPR decision has been made and recorded.

- Or where the person is found deceased without a DNACPR conversation documented and there are signs of irreversible death (e.g. rigor mortis).
- Death occurs in a private residence, hospice, residential home, nursing home, or hospital.

## 7.2 Medical responsibilities

- It is good practice for doctors to see patients regularly to monitor symptom control and provide support and information when they are dying.
- A doctor does not need to have seen a patient within 28 days preceding their death in order for verification of death by an RN/AHP to take place however for them to certify death there is a requirement for the deceased to have been seen by a doctor in their lifetime.
- Certification of cause of death must be done by a doctor in accordance with current National guidance.

## 7.3 RN/AHP responsibilities

- To identify that death has occurred and to be able to confirm the fact of death.
- Verify the death following the examination guide.
- Complete the 'Verification of the Fact of Death Form' – appendix B.

7.4 The fact of death should be communicated to the doctor responsible for the patients' care as soon as possible following death. In the community setting, in-hours this may be the patients' own GP, or out-of-hours this may be the GP out-of-hours service. A copy of the completed forms should be left with the patient / family for the funeral director; they should be photographed / photocopied, uploaded to Rio records and sent by secure email to the GP surgery. In the Hospital setting the form is to be filed as the last entry in the patient notes.

7.5 The verification of fact of death form will be required by the doctor involved in the patients care in order for a medical certificate for the cause of death to be written at the earliest available opportunity.

7.6 Parenteral drug administration equipment (for example as syringe driver) can be paused or stopped if alarming, prior to the process of a verification examination but can only be removed once verification of death has been completed.

7.7 For patients with **Non-Invasive Ventilation devices (NIV)** i.e. CPAP; BIPAP. For the majority of patients assisted ventilation does not complicate the dying process; if it's benefit has been lost, then those using NIV only at night may simply choose not to put it back on. For others, NIV may continue to provide benefit throughout the



dying process, it is suggested that around half of patients using NIV in the UK die having stopped it themselves (not put it back on at some point) and half die while still using NIV.

When death occurs with NIV remaining in situ it will be evident that death has occurred, but the NIV device continues to administer air until removed. In these cases, verification of death can be carried out as per the examination process. A small but potentially increasing number of patients who are dependent on NIV, request that the assisted ventilation is withdrawn because of deterioration in their quality of life due to disease progression. For those patients, please refer to the Association for Palliative Medicine guidance for professionals 'Withdrawal of Assisted Ventilation at the request of a patient with Motor Neurone Disease' (2015) to support planning for withdrawal of ventilation to precede death.

- 7.8 While an **Implantable cardioverter defibrillator (ICD)** is in place the RN/AHP must instigate the process for deactivation where applicable following the Deactivation of ICD Pathway (Appendix F) prior to expected death. However, if the ICD is active at time of death the patient's family should be reminded that if the device does discharge, it is by means of a low energy internal shock which will not physically harm them, although it may cause the body to move, this may cause psychological distress. It is safe to touch a body and verify death even if the device has not been deactivated.
- 7.9 Pacemakers discharge a low current. After death they will not produce an ECG complex and a pulse will not be present, although you may still see a small spike on an ECG. You can still verify a death if a patient has a pacemaker in situ. Funeral directors will remove pacemakers if the person is being cremated as they can explode. In burial they are usually left in place. Funeral directors, mortuary staff and coroners must be informed of all internal and external pacemakers the patient may have in place at death. A form is available to use in such circumstances (Appendix H).
- 7.10 The RN/AHP carrying out the verification of death must notify the funeral director or mortuary of any confirmed or suspected infections, radioactive implants, implantable devices and whether an ICD is still active so it can be arranged for them to be deactivated after death. In the acute Trust the Bereavement and Medical Examiner Office will notify the funeral directors by way of completing an implantable device notification form (Appendix G).
- 7.11 The RN /AHP verifying the death must acknowledge the emotional impact of the death and ensure the bereaved family and friends are offered information about "the next steps", to ensure the family are supported during this difficult time. The RN/AHP verifying death should understand the potential / actual emotional impact of bereavement on surrounding patients and residents in a communal setting and prompt colleagues and paid carers to provide appropriate support. The RN verifying death should understand the potential / actual emotional impact of bereavement for colleagues and carers and guide them towards appropriate support<sup>21</sup>.

- 7.12** It is the right of the verifying RN/AHP to refuse to verify a death and to request the attendance of the responsible doctor, or police if there is any unusual situation.

## **8.0 EXCEPTIONS TO VERIFYING DEATH**

- 8.1** There will be exceptions where a RN/AHP cannot verify death, and the doctor should be called:
- If the patient is under 18 years of age.
  - Any adult death believed to have occurred in suspicious circumstances.
  - Where organ/tissue donation has been requested and urgent medical intervention is needed to remove the appropriate organ/tissue or make the appropriate arrangements.
  - Where relatives specifically request to see the Doctor/ GP.
  - When the RN/AHP has a good reason for needing the support of a Doctor/GP.
  - When the Doctor/ GP feels he/ she should be present.
- 8.2** If anything, untoward or unlawful is suspected please contact the line manager (on call manager out of hours) who will discuss if the police need to be involved. If they do, please preserve the scene, and later complete an incident form.
- 8.3** In the community setting, in instances of doubt regarding evidence of expected nature of death at the home, the RN/AHP should contact a senior colleague/manager for advice. They would then be able to review contemporaneous records for evidence that may not be present in the home and support the decision maker.

## **9.0 NOTIFYING THE CORONER**

- 9.1** It is the doctor's responsibility to refer the death to the Coroner for investigation in the following circumstances, NB. these are not reasons to exclude RNs/AHPs from verifying the fact of death:

### **Unknown cause of death.**

- The deceased was not seen by the certifying doctor within their lifetime
- Death related to any treatment or procedure of a medical or similar nature (including during an operation or before recovery from the effects of an anaesthetic).
- Patient has recently suffered a fall or other kind of accident.
- Death is as a result of violence, trauma or physical injury, whether inflicted intentionally or otherwise.
- The death may be due to an industrial disease or related to the deceased's employment (e.g mesothelioma).
- Death occurred as a result self-harm (i.e., potential suicide).
- Death occurred as a result of neglect (including self-neglect by the deceased) or failure of care by another person.

- Death occurred due to use of a controlled drug. Medicinal product or toxic chemical.
- The death occurred during or shortly after state detention (i.e., prison or police custody), or any other form of police involvement.
- The death occurred while the deceased was subject to compulsory detention under the Mental Health Act.

## **10.0 VERIFICATION OF DEATH EXAMINATION**

- 10.1 Risk assessment of Infection Control precautions: Personal Protective Equipment (PPE) should be worn as per universal infection control precautions when carrying out verification of death for non-aerosol generating procedures and where COVID-19 is suspected or confirmed cover the patient's mouth and ventilate the room where able.
- 10.2 Carry out the Verification of Death Examination and record it on the Verification of fact of death form (Appendix B).

## **11.0 TRAINING / COMPETENCE GUIDANCE**

- 11.1 An RN/AHP may only undertake verification of expected death if they have attended either face to face training and been assessed as competent, or completed the eLearning on Verification of Death, passed the eLearning and been assessed as competent through supervised clinical work specific to place of work (Appendix E).
- 11.2 Training for RNs and AHPs with a 3 yearly refresher required.
- 11.3 Unregistered carers can support the registered practitioner carrying out the VOD practical process, and may attend training to allow them to understand how best to do this, but the registered practitioner that they are partnered with for the procedure must complete the practical and administrative tasks themselves as part of the process.

## **12.0 MONITORING COMPLIANCE AND EFFECTIVENESS**

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency /reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
----------------------------------	---------	---	-----------	---	--

<i>Verification of the Fact of Death form</i>	<b>10.2</b>	An audit of documentation appendix B will be completed according to the Trust's record keeping policy. Audit standards have been developed (Appendix F).	EOL Steering Group Chair (can be delegated)	Initially annually; the first audit will indicate risk level and required frequency	Monitoring by the EOL Steering Group
<i>Whole policy</i>	<b>Whole</b>	All incidents, feedback and complaints related to verification of expected death	EOL ICB Prog Board	6 monthly review of complaints	Any good practice and/or learning points will be fed back to the relevant Best Practice Groups. Clinical supervision sessions will be offered to staff involved in any VOD incidents.

## 13.0 REFERENCES

### References cited in text

- Goodman C, Knight D, Machen I, Hunt B. Emphasising terminal care as District Nursing work: a strategy in a purchasing environment? *Advanced Journal of Nursing*, 28 (3), 491 – 498. 1998.
- National Council for Palliative Care (2015). Every moment counts: a narrative for person centred coordinated care for people near the end of life. Available at: [http://www.nationalvoices.org.uk/sites/default/files/public/publications/every\\_moment\\_counts.pdf](http://www.nationalvoices.org.uk/sites/default/files/public/publications/every_moment_counts.pdf)
- Department of Health and Social Care (2020) Coronavirus (COVID-19): verifying death in times of emergency. Published 5 May 2020. Available at: <https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verifying-death-in-times-of-emergency#key-resources>
- 4 & 13. Royal College of Nursing (RCN) 2016: *Confirmation or verification of death by registered nurses* [online] <https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death>
- 5. Griffith R. Human rights and district nursing practice. *British Journal of Community Nursing*, 9 (12), 535-539. 2004.
- 6. Royal College of Nursing (2020). Confirmation or verification of death by registered nurses. Available at: <https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death>
- 7 & 12. Publication: Decisions relating to cardiopulmonary resuscitation (3rd edition - 1st revision) (2016) Resuscitation Council UK. Available at: <https://www.resus.org.uk/library/publications/publication-decisions-relating-cardiopulmonary>
- 8. Hospice UK (2022). Care after death: guidance for staff responsible for care after death (4<sup>th</sup> edition). Available at: <https://www.hospiceuk.org/what-we-offer/publications?cat=72e54312-4ccd-608d-ad24-ff0000fd3330>
- 9. Academy of Medical Royal Colleges (2008). A code of practice for the diagnosis and confirmation of death. Available at: <http://www.aomrc.org.uk/publications/reports-guidance/ukdec->

- 10. Hospice UK (2020). Care after death: guidance for staff responsible for care after death (third edition). Available at: <https://www.hospiceuk.org/what-we-offer/publications?cat=72e54312-4ccd-608d-ad24-ff0000fd3330>
  - 11. Office for National Statistics (2018). Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales. Updated 1 April 2020. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/757010/guidance-for-doctors-completing-medical-certificates-of-cause-of-death.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757010/guidance-for-doctors-completing-medical-certificates-of-cause-of-death.pdf)
  - 14 & 18. British Medical Association (BMA) Confirmation and Certification of Death – Guidance for GPs in England and Wales. November 2019. Available from: [www.bma.org.uk/advice/employment/gp-practices/service-provision/confirmation-and-certification-of-death](http://www.bma.org.uk/advice/employment/gp-practices/service-provision/confirmation-and-certification-of-death)
  - 15. UK Legislation. Coronavirus Act 2020. March 2020. Available from: [www.legislation.gov.uk/ukpga/2020/7/contents](http://www.legislation.gov.uk/ukpga/2020/7/contents)
  - 16. Gov.uk Register the death [www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner](http://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner) (January 2013)
  - 17. Somerset Council (June 2023) Register a Death. Available from: <https://www.somerset.gov.uk/births-ceremonies-and-deaths/register-a-death/>
  - 19. HM Passport Office, Completing a medical certificate of cause of death (MCCD) guidance. March 2022. Available from: [www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death](http://www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death)
- 
- 20. Association for Palliative Medicine (2015) Withdrawal of Assisted Ventilation at the Request of a Patient with Motor Neurone Disease. Available from: <https://apmonline.org/wp-content/uploads/2016/03/Guidance-with-logos-updated-210316.pdf>
  - 21. Hospice UK (2022). Care After Death: Registered Nurse Verification of Expected Death (RNVoEAD) guidance (5<sup>th</sup> edition). Available at: <https://professionals.hospiceuk.org/what-we-offer/publications?cat=72e54312-4ccd-608d-ad24-ff0000fd3330>
  - 22. Public Health England (2020) COVID-19: personal protective equipment use for non- aerosol generating procedures. Updated 21 August 2020. Available at: <https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures>
  - 23. **[What is the Somerset Medical Examiner Service? | Resources | Somerset - End Of Life Care & Bereavement Support \(eolcare.uk\)](#)**
  - 24. [An overview of the death certification reforms - GOV.UK \(www.gov.uk\)](#)
  - 25. [The Medical Certificate of Cause of Death Regulations 2024 \(legislation.gov.uk\)](#)

## 14.0 Cross reference to other procedural documents

- Induction and Mandatory Training Policy
- Record Keeping and Records Management Policy
- Risk Management Policy
- Incident Policy

All current policies and procedures are accessible via RADAR document management system.

## 15.0 APPENDIX A

### VERIFICATION OF DEATH DECISION SUPPORT TOOL

<b>Patient's Name</b>			
<b>NHS Number</b>			
<b>Date of Birth</b>			
<b>GP</b>			
<b>Is the patient over 18 years old?</b>			
<b>YES – proceed</b>		<b>NO – refer to the Doctor</b>	
<b>Are there any obvious suspicious circumstances which preclude verifying the fact of death?</b>			
<b>NO – proceed</b>		<b>YES - call manager/Police</b>	
<b>Are there any concerns of the family which preclude verifying the fact of death?</b>			
<b>NO – proceed</b>		<b>YES – call manager</b>	
<b>Is there good reason for needing the support of a Doctor / GP?</b>			
<b>NO – proceed to verify death</b>		<b>YES – call manager</b>	
<b>Please give details of rationale</b>			
<b>Is this an expected death?</b> ie. DNACPR decision or other supporting evidence in place ie. JIC meds; CHC funding; Pallative care paperwork	<b>YES</b>	<b>DETAILS, please record:</b>	
	<b>NO</b>		
<b>Is this a sudden but not unexpected death?</b> ie. No DNACPR documentation but death anticipated or related to a previously known illness and CPR would be futile	<b>YES</b>	<b>DETAILS please record:</b>	
	<b>NO</b>		
<b>Is this sudden and unexpected but there are irreversible signs of death?</b> ie. Rigor mortis indicating dead for sometime, as such CPR would be futile	<b>YES</b>	<b>DETAILS please record:</b>	
	<b>NO</b>		
<b>NAME</b>	<b>SIGNATURE</b>	<b>DATE</b>	<b>TIME</b>

## 16.0 APPENDIX B - VERIFICATION OF THE FACT OF DEATH

<b>Are you satisfied the patient death can be verified?</b>							
<b>YES</b> – proceed to verify death				<b>No</b> – call manager			
<b>Place of death</b>							
<b>Date and suspected time of death</b>							
<b>People present / found by</b>				<b>Contact Number</b>			
<b>Patients Next of Kin</b>				<b>Contact Number</b>			
<b>PATIENT NAME</b>				<b>DATE OF BIRTH</b>			
<b>Patient Address</b>							
<b>NHS NUMBER</b>							
<b>Registered GP</b>				<b>GP informed</b>			
<b>Observe over 5 minutes</b>				<b>Date</b>		<b>Time</b>	
<b>Signature</b>							
<b>1</b>	<b>Absence of motor response by performing a trapezius squeeze</b>						
<b>If no response proceed</b>							
<b>2</b>	<b>Absence of a carotid pulse over 1 minute</b>						
<b>3</b>	<b>Absence of pupillary response to light</b>						
<b>Remove supplementary oxygen or Non-Invasive Ventilation mask if in place and re-start 5 minutes of monitoring</b>							
<b>4</b>	<b>Absence of respiratory effort and breath sounds over the 5 minutes</b>						
<b>5</b>	<b>Absence of heart sounds over 1 minute</b>						
<b>Any spontaneous return of cardiac or respiratory activity repeat a further five minutes of observations</b>							
<b>6</b>	<b>VERIFIED DATE AND TIME OF DEATH</b>						
Relatives Neighbour contacted				YES		NO	
Minister of Religion contacted if required				YES		NO	
Necessary advice and documentation given to relatives				YES		NO	
Other services involved in care informed (ASC, Hospice, Marie Curie)				YES		NO	
CQC informed if patient is detained under the Mental Health Act in an inpatient unit:				YES		NO	
There is a completed application for body donation to medical science				YES		NO	
Funeral Director (if known)							
Where is the body to be taken (if known)							
Plan for cremation or burial (if known)							
<b>Verified by: NAME (please print)</b>				<b>Signature:</b>		<b>Qualification: (e.g. RN / Physio)</b>	



## 17.0 APPENDIX C

**Procedure for completing and submitting the CQC form: 'Statutory notification about the death of a person detained or liable to be detained by the registered person under the Mental Health Act 1983'.**

This form must be completed whenever any patient subject to powers within The Mental Health Act dies, no matter what the circumstances of the death.

This includes patients subject to Sections within Part II of the Act (2, 3, 4, 5, 7, 17, 17A, 135, 136) and patients subject to Sections within Part III of the Act (35, 36, 37 (with or without S41 restrictions), 38, 44, 47, 48).

The form is periodically amended by CQC and can be accessed via:

[www.cqc.org.uk/mhanotifications](http://www.cqc.org.uk/mhanotifications)

### Procedure

1. Nurse in charge of the ward (or care coordinator for CTO patients) completes electronic CQC form and an incident form
2. Nurse or care coordinator e-mails completed form to the Mental Health Act administrators
3. Administrator e-mails it to MHA coordination manager and Legal Strategies manager
4. Managers check form for accuracy and liaise with the person who completed the form if there are any gaps, or if anything requires further explanation
5. Managers return form to administrators and copy in corporate governance manager
6. Administrator e-mails form to CQC using a secure NHS.NET account.

## 18.0 APPENDIX D

### Reference guide regarding inclusion / exclusion criteria for RN/AHP verification of death

#### INCLUSION CRITERIA:

For all RNs/AHPs, trained and competent, working within their care setting to verify the death of all adults (over the age of 18) and where the following conditions apply:

- Not accompanied by any suspicious circumstances;
- Death is expected, evidenced by supporting information i.e.. DNACPR decision;
- Death is sudden yet not unexpected, where for whom attempting CPR is clearly inappropriate ie. a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal DNACPR decision has been made and recorded;
- Where the person is found deceased without a DNACPR conversation documented and there are signs of irreversible death (e.g. rigor mortis).
- Death occurs in a private residence, hospice, residential home, nursing home, or hospital.

#### EXCEPTIONS TO VERIFYING DEATH

There will be exceptions where a RN/AHP cannot verify death and the doctor should be called.

- If the patient is under 18 years of age;
- Any adult death believed to have occurred in suspicious circumstances;
- Where relatives specifically request to see the Doctor/ GP;
- When the RN/AHP has a good reason for needing the support of a Doctor/GP;
- Where the Doctor/ GP feels he/ she should be present.

If anything untoward or unlawful is suspected staff are to contact the manager (on call manager out of hours) who will discuss if the police need to be involved.

**NB. It is the right of the verifying nurse to refuse to verify a death and to request the attendance of the responsible doctor, or police if there is any unusual situation (Hospice UK 2022).**

## 19.0 Appendix E

### Learning Contract and Competency Framework for: Verification of Death in Adults

#### LEARNING CONTRACT

<b>Learner Name</b>	
<b>Learner post / role</b>	
<b>Ward / Dept</b>	
<b>Assessor Name</b>	
<b>Assessor post / role</b>	
<b>Ward / Dept</b>	
<b>Line Manager</b>	
<b>Manager post / role</b>	

<b>Competency to be achieved</b>	Verification of Death in Adults
<b>Underpinning documents (National guidance, Trust policies)</b>	Assessing Competence in Clinical Practice Protocol Verification of Death of Adult Patients by Registered Nurses and Allied Health Professionals Induction and Mandatory Training Policy Record Keeping and Records Management Policy Risk Management Policy Incident Policy
<b>Pre-requisite standards for competence i.e. qualifications</b>	Registered Nurse or Registered Allied Health Professional
<b>Learning need identified in PDP/Appraisal</b>	
<b>Learning contract supported by Line Manager</b>	

<b>Learner signature</b>		<b>Date:</b>
<b>Assessor Signature</b>		<b>Date:</b>

## COMPETENCY FRAMEWORK

Learning objectives	How is Learning evidenced? (Questioning/direct observation/simulation/workbook completion etc)	Date	Assessor signature
<p><b>Awareness of the following:</b></p> <p>Trust policy and related guidance documents</p> <p>Who can recognise a death?</p> <p>Who can verify a death?</p> <p>Who can certify death?</p> <p>What is an expected death?</p> <p>Demonstrate understanding of evidence of expected death.</p> <p>What is a sudden but not unexpected death?</p> <p>Demonstrate clear rationale of where death is not unexpected.</p> <p>What is a sudden unexpected death with signs of irreversible death?</p> <p>Demonstrate clear rationale that death is irreversible.</p> <p>What is a DNACPR decision?</p> <p>What are the inclusion criteria for RN/AHP verification of death?</p> <p>What are the exceptions to RN/AHPs verifying death?</p> <p>What are the circumstances for notifying the coroner?</p> <p>What are the medical responsibilities?</p>			

<p>What are the RN / AHP responsibilities?</p> <p>What is the definition of official time of death?</p> <p>Requirements for notification of infectious diseases?</p> <p>Management of ICD Implants and their deactivation?</p> <p>Equipment required for verification of death examination.</p> <p>How to manage parental drug administration (ie. Syringe drivers)</p> <p>PPE requirements for safe procedure</p>			
<p><b>Procedure:</b></p> <p>Understands that the patient must be observed for a minimum of five minutes to establish that irreversible cardio-respiratory arrest has occurred.</p> <p>Ensures that the absence of motor response to trapezius squeeze is tested.</p> <p>Ensures absence of heart sounds on auscultation.</p> <p>Ensures both eyes are tested for the absence of pupillary response to light.</p> <p>Ensures absence of respiratory effort by observation over the five minutes.</p> <p>Ensures absence of a central pulse on palpation.</p> <p>Ensures that any spontaneous return of cardiac or respiratory activity during this period of observation would prompt a further five minutes of observation.</p> <p>Demonstrates correct infection control precautions throughout, including cleaning of equipment post procedure.</p>			

<p><b>Documentation:</b></p> <p>How to complete the local Verification of Death Decision Support Tool.</p> <p>How to complete the local Verification of the Fact of Death Form.</p> <p>How to accurately record time of death.</p> <p>How to notify the medical team.</p>			
<p><b>Support to those involved:</b></p> <p>Understands the emotional impact of bereavement on family and friends.</p> <p>Demonstrate how they would support family and friends involved.</p> <p>Understands the emotional impact on colleagues and paid carers.</p> <p>Demonstrate how they would support colleagues and paid carers involved.</p> <p>Knows the support information available for bereaved family and friends.</p> <p>Knows how to signpost relatives to where to collect paperwork and the next steps.</p>			

**Assessment Feedback**

**I confirm that..... is competent to carry out:**

**Signed: ..... Role:..... Date:.....**

**Learner Review**

**I confirm that I feel confident of my competence to carry out:**

**Name..... Role:..... Date:.....**



### PATHWAY FOR THE DEACTIVATION OF INTERNAL CARDIOVERTOR DEFIBRILLATORS (ICDs)

#### DISCUSS DEACTIVATION WITH PATIENT / CARERS AT THE FOLLOWING POINTS OF CARE.

- Prior to implantation
- Patient experiencing repeated inappropriate activations from ICD
- No longer clinically appropriate or a patient wishes to deactivate
- When a 'DNACPR' decision has been made or a decision to limit treatment options that would allow a natural death, this should be recorded on the TEP chart
- Patient on EPaCCS (electronic palliative care co-ordination system) or palliative care end of life register
- Development of a life limiting condition and prognosis less than 12 months
- If conditions are met for an advance decisions document

**ADVICE AVAILABLE FROM ARRHYTHMIA NURSE SPECIALISTS AT MPH**  
**01823 343595, ANS@somersetFT.nhs.uk**

DECISION TO DEACTIVATE AGREED WITH PATIENT, FAMILY OR THOSE IMPORTANT TO THE PATIENT

CONSIDER MENTAL CAPACITY ACT  
(Refer to policy on the trust intranet)

IN HOURS MON-FRI  
09:00-17:00

From outside MPH call 01823 342953 to speak to Cardiac Physiologists. Please provide:

- Patients name and DOB
- Place of patient care and telephone number
- Why deactivation is required
- Urgency
- Contact details of clinician (Tel/Bleep/Mobile)
- Any known details of device including manufacturer (if known)

Cardiac Physiologist to contact Consultant Cardiologist. If in agreement direction for physiologists to deactivate ICD recorded in clinical notes. If YDH patient, contact Senior Nurse Cardiology or Arrhythmia Nurse to arrange deactivation and inform physiologist at MPH

Physiologist contacts place of care and organises the visit as soon as possible but within 2 working days. At visit physiologist assesses patient and may discuss further with Consultant Cardiologists at MPH.  
Deactivate Device

OUT OF HOURS  
IF DEATH IS EXPECTED BEFORE  
NEXT IN HOURS PERIOD  
17:00 -09:00 Mon-Fri  
24 hours Sat, Sun and B/H

If the Doctor responsible for care feels deactivation is appropriate and urgent, discussion with patient and/or family should take place. If further advice required: please contact the duty cardiologist or St Margaret's Hospice advice line. All such conversations must be recorded in clinical notes and the Doctor is responsible for communication with relevant local nursing and care teams

Magnet applied as per 'How to use a magnet guide' and magnet application chart completed. Magnets located: MPH 'Pacing Defib' crash trolleys, OOH, Hospices, Emergency Response Vehicle, YDH A&E, and Community Hospitals.

**Cardiac Physiologists at MPH or YDH appropriately MUST be contacted urgently on the next working day to arrange ICD programmed deactivation.**

Authorisation for removal of implantable devices from a deceased patient

This patient has a **PPM / ICD** (delete as appropriate) in situ

Patients Name .....MRN.....

It has been explained to me that in order to comply with cremation regulations pacemakers, and other implantable devices, must be removed prior to cremation.

'I therefore give my consent for the mortuary technician or Funeral Director to remove any implantable devices'.

Name: .....

Telephone No: .....

Are you the next of kin?      Yes      No      (please circle)

If no please state your relationship to the deceased person.....

Signed .....

Date .....

For Mortuary use only

Removed by .....

Signed .....

Date .....

**NOTIFICATION OF AN IMPLANTABLE MEDICAL DEVICE**

This following patient has an implantable medical device in situ.

Patients Name	
Date of Birth	
NHS Number	
Address	
Device in situ	
If this device is an internal cardiac defibrillator, has it been deactivated?	
Signed	
Print name	
Role	
Date	

Please complete this form and email to the Funeral Director who has been instructed by the patients family.

## 23.0 Appendix J Audit Standards

The audit data is collected as detailed below:

STANDARD <i>(remove/add rows as needed)</i>		REFERENCE <i>(e.g.policy/NICE paragraph number)</i>	EXCEPTIONS	TARGET COMPLIANCE (%)			Details of exactly where in notes this information should be recorded, as well as any interpretations and definitions
				%-% (Red)	%-% (Amber)	%-% (Green)	
1	The death should be verified within 1 hour of death timed and dated in patient notes for those patients who died in the acute hospital, Community Hospital and Hospice	5 th Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance	Serious Incident	<90%	91-99%	100%	Serious incident must be evidenced in notes
2	The death should be verified within 4 hours of death timed and dated in patient notes for those patients who have died in the community	5 th Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance	Patients' family delay the verification for spiritual/cultural practice	<90%	91-99%	100%	If the Patients' family delays the verification, there must be evidence in the patients record
3	The 5 steps for verification of death should be completed in chronological order	5 th Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance	None	<90%	91-99%	100%	The steps are as follows:  1. Motor response 2. Heart sounds 3. Neurological response 4. Respiratory effort 5. Central pulse

Verification of Death Policy