Belfast Health and Social Care Trust

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Title:	Guidance on actions to be taken after a patient's death		
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Ownership:	Dr AB Stevens, Medical Director		
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Links to other policies			

Version Record

Date	Version	Author	Comments
30/11/2009	V 1.1	JR Johnston	Maternal death amendments
26/04/2010	V 1.2	JR Johnston	Changes after AH's 14/12/2009 email
25/05/2010	V 1.3	JR Johnston	CMACE manager name change 8.10 signature & GMC number on MCCD
02/07/2010	V 1.4	O Macleod M Trimble JRJ	Reviewed verification of death, completion of MCCD, contacting Coroner's office. Added hospital post-mortem examination information & Proforma form. Reviewed updated GMC guidance on *Treatment and care towards the end of life* – no change required.
28/07/2010	V 1.5	JR Johnston	Contents page : HCAI infections
23/08/2010	V 1.6	JR Johnston	Coroner Office changes - Dr Clarke
11/10/2010	V 1.7	JRJ	Flowchart amended and format changed
8/11/2010	V 1.8	JRJ	Remove HM; HCAI wording 8.16 + app 2.
05/08/2011	V2.1	CM	Addition of-responsibility to inform relatives of cause of death, - record coroner referred in patient's notes.
14/12/2011	V2.2	CM	Update of Appendix 2 following comments from a Serious Incident Investigation.

07/03/2012	V2.3	CM	Update Appendix 2 following HSC Board letter (6/02/2012) requesting improved timeliness to GP being informed of deaths
1/5/2012	V2.4	JRJ	New format; After S&G on 4/4/12

Guidance on actions to be taken after a patient's death

1.0 INTRODUCTION / PURPOSE OF POLICY

This policy provides guidance on the steps that need to be taken after a patient dies:-

- **confirmation and verification of death, stillbirth.**
- **when and how to liase with the coroner's services.**
- **completion of medical certificates.**
- **cremation certification**

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff on verifying life extinct and to ensure the appropriate steps are then taken.
- ensure that all deaths are reported and recorded in accordance with the Coroner's office.
- ensure that staff deal with the death of a patient in a caring, compassionate and professional manner.
- comply with DHSSPSNI circulars HSS(MD) 3/2008, 8/2008, 10/2008.

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff that have a role in verifying and recording life extinct, death certification and reporting deaths to the coroner's office.

It applies to a variety of settings: wards, ICU/CCU, emergency department and community.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

When a person dies, a number of steps need to be completed to allow confirmation, certification and legal registration of the death. These steps are:

A. Verifying life extinct.
B. Certifying the medical cause of death or
C. Referral to the Coroner.
D. Registering the Death.
E. Obtaining a burial or cremation order.

3.0 ROLES/RESPONSIBILITIES

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Doctors are responsible for completing a Medical Certificate and Cause of Death (MCCD). The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

Those verifying and certifying death must be aware of the roles of Health and Social Care, the Police Service of Northern Ireland and the Coroner's Office in the process of dealing with death.

4.0 KEY POLICY PRINCIPLES

A. Verifying life extinct.

4.1 This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

4.2 In order to verify life extinct, cessation of circulatory & respiratory systems and cerebral function must be confirmed and documented in the patient's notes - appendix 1.

Further details of the process for confirming death are given in appendix 3 and from the "A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008)".

4.3 Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

4.4 Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death (appendix 2).

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death.

4.5 Where there are concerns about the death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct how the death should be handled.

4.6 There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

B. Certifying the medical cause of death, stillbirth.

4.7 Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange disposal of the body and settle their estate.A doctor who had treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).

4.8 All doctors completing medical certificates of cause of death or cremation forms and doctors and midwifes completing stillbirth forms should be aware of when and how to complete the forms and when deaths should be referred to the coroner.

4.9 All staff should refer to the DHSSPSNI guidance on Medical Certification and Cause of Death (MCCD), when completing a death certification / liasing with the Coroner. This can be found at the link below:

http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf

An expected death can be defined as: "a death where the patient's demise is anticipated in the near future". In such cases the doctor will be able to issue a medical certificate as to the cause of death.

Where there is a death in suspicious circumstances or a sudden /unexpected death nursing and medical staff must be familiar with the necessary steps required to deal with this situation – outlined in appendix 2. These procedures should be handled in a sensitive and knowledgeable way.

4.10 Registered Medical Practitioners have a legal duty to provide, without delay, a certificate of cause of death if, to the best of their knowledge, that person died of natural causes for which they had treated that person in the last 28 days.

4.11 Any alterations to the MCCD must be initialled by the doctor.

4.12 Because Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a

- legible printed name,
- signature
- GMC number beside your signature and
- contact details. Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

4.13 It is good practice to either make a note in the clinical record of the details recorded on the MCCD, or keep a copy of the MCCD in the patient's records.

4.14 It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

4.15 If a doctor cannot complete an MCCD, either because the cause of death was not natural or because they were not treated in the final 28 days of life, then the death must be referred to the Coroner. If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

A doctor who had not been directly involved in the patient's care at any time during the illness from which they died cannot certify the cause of death, but should provide the coroner with any information that may help to determine the cause of death.

If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) then the duty doctor may contact the Coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland)*.

If the Coroner agrees this approach, you will be asked to draft a completed but unsigned MCCD giving the cause of death as agreed and a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). These are both to be faxed through to the Coroner's office (both originals should then follow in the post).

It is also good practice to inform the patient's GP if death occurs in hospital.

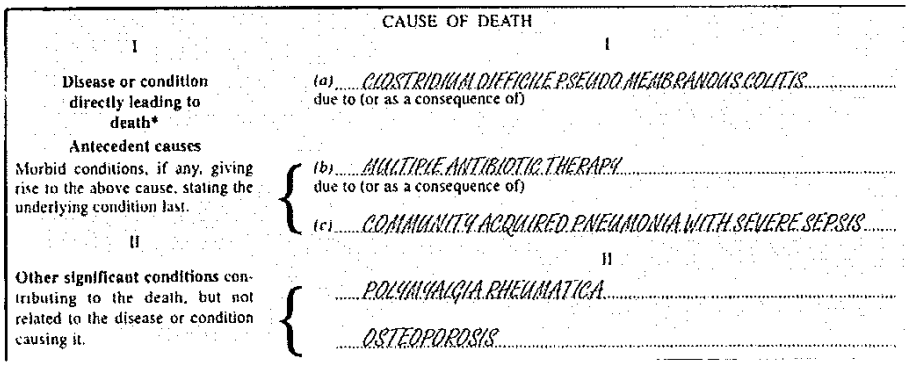
4.16 **Recording Healthcare Associated Infections (HCAI)**
The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.

The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease
i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDOMEMBRANOUS COLITIS
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.

(b) MULTIPLE ANTIBIOTIC THERAPY
due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

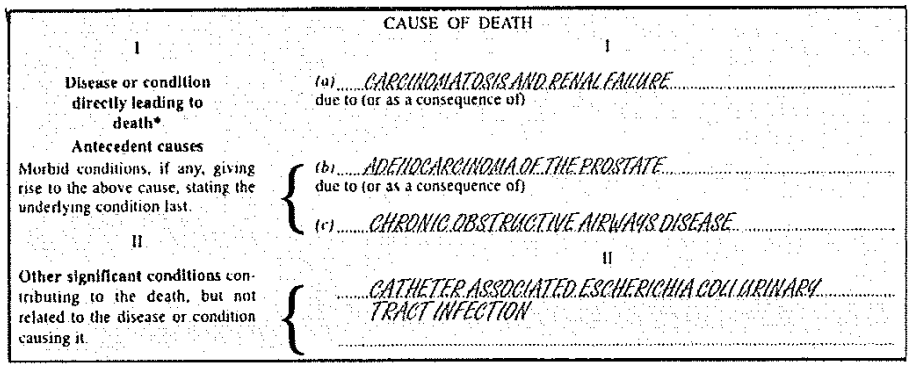
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it.

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.



CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.

(b) ADENOCARCINOMA OF THE PROSTATE
due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it.

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to be contributory to a patient's death it is important not to record it on the MCCD.

The recommended sequence should be:-

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** ward manager/nurse in charge that MCCD with contributory HCAI has been issued.
4. **Assist** ward manager/nurse in charge in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
- Consultant advice.

C. Referral to the Coroner.

4.17 There is a general requirement under section 7 of the Coroners Act (NI) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

Notification to the coroner and any discussions with the coroner should be recorded in the patient's notes.

For information regarding the Coroner's office refer to
http://www.coronersni.gov.uk/publications/Coroners_Service.pdf

4.18 Therefore, before you proceed with completing a MCCD ask yourself this question – *Does this Death have to be reported to the coroner?*

For help, refer to appendix 4 and/or
Guidance on Death, Stillbirth & Cremation Certification. **DHSSPSNI, 2008.**

4.19 Notification to the Coroner of the death of a child must be done by a Consultant.

4.20 Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed.

If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns. A written record of these concerns should always be made and retained with the medical records.

4.21 A foundation level doctor must consult a more senior colleague before reporting a death to the coroner.

4.22 A death occurring in hospital during the night does not usually need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning. A coroner is always on call and can be reached if necessary out-of-hours. Where there is a need to obtain consent for the transplantation of organs or some other complicating factor arises, the death should be reported to the coroner as soon as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

4.23 The office of the Coroners Service for Northern Ireland is at:

- May's Chambers, 73 May Street, Belfast BT1 3JL.
- Tel: 028 9044 6800; Fax 028 9044 6801.
- Website: www.coronersni.gov.uk
- E-mail: coronersoffice@courtsni.gov.uk
- the office is staffed weekdays 9.00am – 5.00pm,
- weekends and public holidays 9.30am – 12.30pm (except Christmas Day when the office is closed)
- outside normal office hours a recorded message will provide contact details for the duty coroner or messages may be left on the telephone answering machine.

NB: If a doctor contacts the Coroner's Office out of hours *they should listen to the full range of options* on the recorded message before selecting one as the most appropriate option may not be clear until the message is complete.

4.24 **Hospital Post-Mortem Examinations**

In some cases, where the nature of the terminal illness is unclear, or the cause of death is uncertain, but there are no concerns that the death was not due to natural causes, a hospital post-mortem examination may be requested.

The decision to request a hospital post-mortem examination in an adult should be taken by a senior doctor, e.g. ST3 grade or above. Any request for a hospital post-mortem on a child must be made by a consultant.

In these cases, the next of kin must be counselled and made conversant of the reasons why a post-mortem examination would be desirable and written consent must be obtained. Information books and consent forms are available for neonatal, paediatric and adult examinations - Post Mortem Examinations DHSSPS(NI).

4.25 **Definition of a maternal death – ICD code 9/10.**

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self harm as consequence of postnatal depression.

A **Coincidental (fortuitous)** death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

4.26 For detailed guidance please refer to the BHSCT policy on "management of a maternal death" - http://intranet.belfasttrust.local/Policies%20and%20Procedures/Management%20of%20a%20Maternal%20Death.pdf

4.27 When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

4.28 **Centre for Maternal and Child Enquiries" (CMACE)**
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that Maternal deaths are reported to the CMACE (Centre for Maternal and Child Enquiries) i.e. the Maternal Mortality Enquiry. It is commissioned and monitored by the National Patient Safety Agency (NPSA).

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the CMACE Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

4.29 CMACE in Northern Ireland is commissioned by the DHSSPS through the Public Health Agency for Northern Ireland and can be contacted through:-
Regional Manager: Dr Jackie McCall

Address:
Public Health Agency (PHA)
Eastern Office (Floor 2)
12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
[redacted] or [redacted]

Fax:
028 9053 5500
Email: Jackie.mccal[redacted]

D. Registering the Death.

4.30 The family (or certain other people) will provide the person's details to the local registrar, with either the MCCD or the Coroners form giving the cause of death.

E. Obtaining a burial or cremation order.

4.31 The registrar or coroner can issue a burial or cremation order.

4.32 Cremation

When a body is to be cremated there are a series of special medical forms to be completed by different, independent doctors, to provide reassurance that the death does not require further investigation. If the death has not been referred to the coroner, and a MCCD - certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

4.33 Form B

This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C

The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F

This is completed by the Medical Referee for the Cremation Authority.

Stillbirth

Stillbirth forms can be completed by a medical practitioner who was present at the birth, or who examined the body.

Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.

A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

5.0 IMPLEMENTATION OF POLICY

6.0 MONITORING

Monitoring of MCCDs will be done by checking the concurrent entry of death certification details onto a new IT system to be introduced in 2012.

7.0 EVIDENCE BASE / REFERENCES

1. DHSSPSNI guidance on death, still birth and cremation certification – 2008.
2. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges. 2008.
3. DHSSPSNI circulars

References, including relevant external guidelines:

1. Guidance on Death, Stillbirth & Cremation Certification, Part A **DHSSPSNI, 2008.**
2. Guidance on Death, Stillbirth & Cremation Certification, Part B **DHSSPSNI, 2008.**
3. A code of practice for the diagnosis and confirmation of death. **Academy of Medical Royal Colleges, 2008.**
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. http://www.coronersni.gov.uk/publications/Coroners_Service.pdf - Coroner's Service, July 2008.
9. *Working with the Coroner's Service for Northern Ireland*

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Verification of Life Extinct
Appendix 2: Protocol for actions to be taken after a death in Hospital
Appendix 3: Diagnosing and confirming death after cardiorespiratory arrest
Appendix 4: Deaths that must be reported to the coroner

10.0 EQUALITY STATEMENT

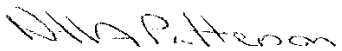
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

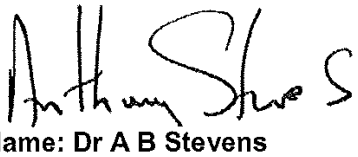
No impact. ☒

SIGNATORIES



Date: March 2012

Name: Nicki Patterson
Title:
Co-Director Nursing Workforce Planning and Development



Name: Dr A B Stevens **Date: March 2012**
Title:
Medical Director

Appendix 1
VERIFICATION OF LIFE EXTINCT

Verifying life extinct can be undertaken by all doctors and, where service groups deem it necessary, this role can also be undertaken by nurses who are appropriately trained.

In order to verify life extinct, cessation of
- circulatory system
- respiratory system
- cerebral function

must be confirmed and documented in the patient's notes with a name and signature.

The documentation recording the examination undertaken and verifying life extinct should be completed and put in the patient's notes.
(**N.B** This applies whether Doctor or Nurse verifies death).

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
- No pulses on palpation.
- No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing)

2. Cessation of respiratory system e.g.
- No respiratory effort observed
- No breath sounds (verified by listening for one full minute)

3. Cessation of cerebral function e.g.
- Pupils dilated and not reacting to light
- No reaction to painful stimuli

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.**

In these situations active resuscitation should continue until an experienced doctor has verified life extinct.

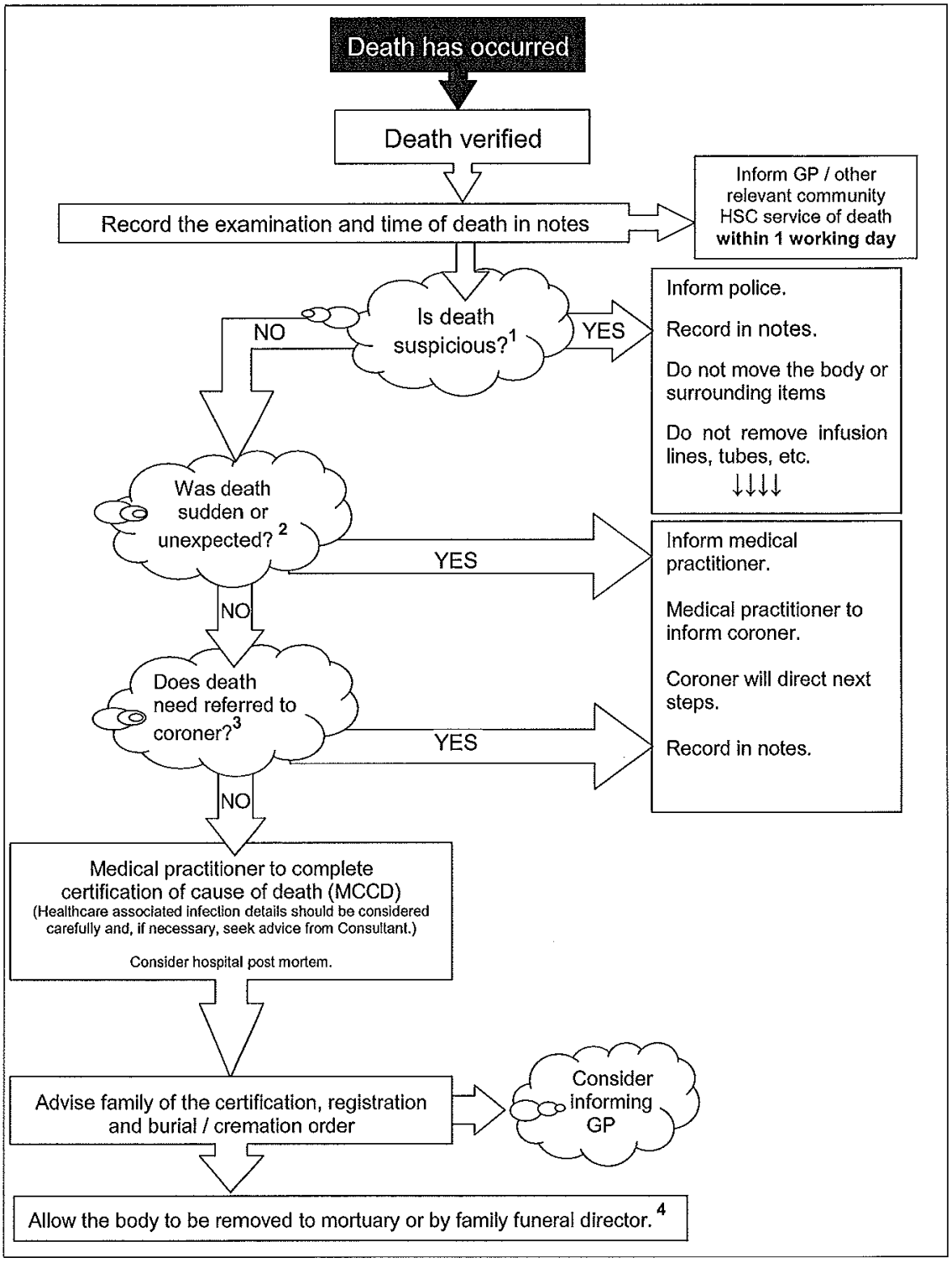
There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. See appendix 3.

From:
HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.

Guidelines for Verifying Life Extinct (PDF 62 KB)

Appendix 2

PROTOCOL FOR ACTIONS TO BE TAKEN AFTER A DEATH IN HOSPITAL



Standards and Guidelines Committee – Guidance on actions to be taken after a patient's death – V3 – May 2012

Notes for Appendix 2

1. **Death involving suspicious circumstances** e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.
   The body must not be moved. Do not disturb the scene.
   There must be immediate contact with the Police and the appropriate medical practitioner (GP, Out-of-Hours Service or hospital medical staff).
   The Police or medical practitioner must contact the Coroner.
   The body will require Post Mortem examination by State Pathology.
   The Police will arrange transfer to a mortuary.

2. **Sudden/unexpected death without suspicious circumstances** e.g. person found dead at home or initial resuscitation is unsuccessful but circumstances do not raise concerns. Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

3. **Death related to specific conditions which need referred to the Coroners Service.** In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

   Contact the appropriate medical practitioner who must contact the Coroner. The coroner may direct a post mortem examination either by a hospital pathologist or by State Pathology. If the coroner is content that post mortem examination is not required a pro-forma letter to the coroner can be completed by the doctor, and the body released to the family's funeral director. If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the persons normal GP is available to discuss the case) the body should be taken to the designated hospital mortuary. The Police will arrange transfer to a mortuary on behalf of the coroner.

4. **Paediatric deaths**
   In certain paediatric cases, parents have the opportunity to take the body of their child home prior to the funeral and where appropriate this choice should be offered. The GP must be informed that this is happening.

Appendix 3

DIAGNOSING AND CONFIRMING DEATH AFTER CARDIORESPIRATORY ARREST

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section [5]

- One of the following is fulfilled:
  - — the individual meets the criteria for not attempting cardiopulmonary resuscitation[8]
  - — attempts at cardiopulmonary resuscitation have failed
  - — treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment

- The individual should be observed by the person responsible for confirming death for a minimum of five minutes [9,10] to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
  - — absence of a central pulse on palpation
  - — absence of heart sounds on auscultation

  These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:
  - — asystole on a continuous ECG display
  - — absence of pulsatile flow using direct intra-arterial pressure monitoring
  - — absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Appendix 4

DEATHS THAT MUST BE REPORTED TO THE CORONER

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   - homicidal deaths or deaths following assault;
   - road traffic accidents or accidents at work;
   - deaths associated with the misuse of drugs (whether accidental or deliberate);
   - any apparently suicidal death;
   - all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

6. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

7. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

   - Industrial diseases or poisoning and other poisonings
     - A. Industrial lung diseases
     - B. Other industrial diseases
     - C. Industrial poisoning
     - D. Other poisonings

   - Death resulting from an injury
     - A. Injury
     - B. Indirect injury
     - C. Birth injury
     - D. Operation / anaesthetic

For further detail go to:
http://www.dhsspsni.gov.uk/guidance-death-stillbirth-and-cremation-certification-pt-b.pdf