University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR THE DEATH OF AN ADULT INPATIENT

Reference Number: POL-CL/1935/09	**Version:** 5		**Status:** FINAL	**Author:** Caroline Forman **Job Title:** Improvement and Development Manager - Medical Director's
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1.15	Feb.2021	Caroline Forman	Merger of Trust policies
	2	March 2021	Caroline Forman	Update on who can verify a death
	3	April 2021	Caroline Forman	Further update on verification of death
	4	May 2021	Caroline Forman	Further updates on who can verify a death
	5	Sept 2022	Caroline Forman	• Updates on release and out of hours release • Removal of Cremation Form 5 • Inclusion of Guidelines on Notification of Deaths to the Coroner where there are Safeguarding Concerns • Update on who can refer a death to the Coroner • Update on referral method for
Intended Recipients: All medical and clinical staff.				
Training and Dissemination: Training will be via Divisional registered medical practitioners (doctors, including Foundation Year One Doctors with provisional registration, and Advanced Clinical Practitioners [ACPs]) training, Trust Induction for doctors in training and during				

To be Read in Conjunction With:

- NMC Code of Professional Conduct (2015)
- Special Edition of Care After Death – Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance
- UKCC Scope of Professional Practice (2001)
- The Royal Marsden Manual of Clinical Nursing Procedures
- Office for National Statistics Guidance for Doctors Certifying Cause of Death in England and Wales
- Office for National Statistics - Coding the Underlying Cause of Death
- Luce, T. et al (2003). Review of Coronial Services, Death Certification and Investigation in England, Wales and Northern Ireland. Office CMNd4810. English Home Office Report of the Committee on Death Certification and Coroners
- (1902, 1952 and 2008). The Cremation Acts, and Regulations made thereunder by the Secretary of State for the Home Department
- Ministry of Justice (2008). Cremation Regulations: Guidance for Doctors. Your right to Inspect the Medical Certificates
- Advisory Committee of Dangerous Pathogens (ACDP)
- Trust Policy and Procedures for Patient Placement and Inter / Intra-Healthcare Transfer of Patients with Known or Suspected Infection Risk
- Trust Policy for Handling of Patient's Property and Valuables.

In Consultation with:

- Learning from Deaths Group
- Medical Director (Quality and Safety)
- Lead Medical Examiner
- Divisional Nursing Directors
- Head of Midwifery
- Advanced Clinical Practitioner
- Associate Clinical Director for Palliative Medicine
- Corporate Lead for Advance Clinical Practice
- Resuscitation and Simulation Manager
- Quality Governance Facilitators
- Infection Control Group
- Mortuary Department
- Bereavement Office
- Legal Services

EIRA Stage One Completed: Yes 2009
Stage Two Completed: No

Procedural Documentation Review Group and Assurance Date	
Approving Body and Date Approved	Trust Delivery Group - 28 November 2022
Date of Issue	November 2022
Review Date and Frequency	September 2025 (every 3 years)
Contact for Review	Improvement and Development Manager - Medical Director's Office
Executive Lead Signature	Dr James Crampton, Interim Executive Medical Director

Section	Contents	Page
1.	Introduction	4
2.	Purpose and Outcomes	4
3.	Key Responsibilities / Duties	4
4.	Implementing the Policy and Procedures Relating to the Death of an Adult Hospital Inpatient	5
5.	Care of the Deceased	8
6.	Completion of the Medical Certificate of Cause of Death	12
7.	Notification of Death to Coroner	14
8.	Monitoring Compliance and Effectiveness	20
Appendix 1 (1a and 1b)	Confirmation of Death Form (QHB patients only)	21
Appendix 2	Notice of Death Form	24
Appendix 3	Cremation Form 4 Medical Certificate	25
Appendix 4	Body Donation Following Death	32
Appendix 5	Guidelines on the Notification of Deaths to the Coroner where there are Safeguarding Concerns (Derby and Derbyshire only)	34

POLICY AND PROCEDURES RELATING TO THE DEATH OF AN ADULT HOSPITAL INPATIENT

1. Introduction

This Policy provides a framework for the procedures relating to the death of an adult inpatient within the University Hospitals of Derby and Burton NHS Foundation Trust (the Trust).

2. Purpose and Outcomes

This Policy will:

- Clearly identify responsibilities
- Outline the process and procedures for caring for the deceased
- Ensure that the Trust fulfils all the necessary legal requirements and formal procedures for dealing with deceased
- Ensure that all relevant documentation is completed. This includes information for use in Cremation Forms
- Raise awareness amongst medical practitioners of the criteria for reporting death within the hospital to the Coroner
- Ensure that the Trust meets the legal requirements regarding notification of deaths to the Coroner.

3. Key Responsibilities / Duties

Executive Medical Director (EMD) / Divisional Medical Directors (DMDs) / Divisional Nursing Directors (DNDs)

The EMD is responsible for ensuring that all registered medical practitioners (doctors, including Foundation Year One Doctors with provisional registration and Advanced Clinical Practitioners) [practitioners] adhere to this Policy in order to fulfil legislative requirements and comply with the process for reporting relevant deaths to the Coroner.

The EMD, DMDs and DNDs will support the development and implementation of training for all practitioners in relation to referring cases to the Coroner and the completion of statutory paperwork following a patient's death and raise awareness amongst junior practitioners of their responsibilities for the accurate and timely completion of the Medical Certificate Cause of Death (MCCD).

Registered Medical Practitioners, Advanced Clinical Practitioner (ACP), Night Nurse Practitioners (RDH site), Clinical Site Practitioners (QHB site) [hereafter referred to as Practitioners] and Registered Nurses (RN)

The medical team caring for the patient are responsible for ensuring that a valid Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form is completed and that reviews of the patient's cardiopulmonary resuscitation (CPR) status is carried out on agreed dates unless an indefinite decision has been made (see ReSPECT Policy).

Following confirmation of death by an individual who is not a doctor, a doctor will be responsible for the completion of the MCCD and cremation forms where relevant.

The Practitioner and RN are responsible for speaking to the patient's relatives at an agreed time where relevant.

RNs and Practitioners have a responsibility to be aware of the resuscitation and CPR status of all patients in their care.

They are responsible for informing the Duty Sister / medical team if the deceased's next of kin have requested the early release of the body for burial. For community hospital wards, processes may vary. Ward doctors will complete the MCCD, the body will then be moved to either a local agreed funeral director, or the funeral director chosen by the family. If it is not possible for ward doctors to complete the MCCD, it may be necessary to move the body to the local acute hospital mortuary.

RNs also have a responsibility for ensuring that the process of care for the deceased is carried out according to this Policy and where relevant supporting other members of the ward team to achieve this.

IT IS A DOCTOR'S LEGAL RESPONSIBILITY TO ISSUE THE MCCD AND ENSURE THAT THE IDENTITY OF THE PATIENT IS CORRECT ON THE MCCD.

Learning from Deaths Group (LFDG)

The purpose of the Group is to assist in the review of deaths that occur within the Trust.

Infection Prevention and Control Group (IPCG)

This Group will advise and monitor issues relating to the care of deceased who die of an infection or who have an infection when they die.

Medical Examiner (ME)

The role of the ME is to examine deaths to:

- Agree the proposed cause of death and the overall accuracy of the MCCD
- Ensure that the cause of death has been discussed with the next of kin/informant, establishing if they have any concerns with care that could have impacted/led to death
- Ensure that clinicians refer appropriately to the local coroner
- Inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures.

4. Implementing the Policy

The Process for Confirmation of Death

This process will ensure that:

- The Trust fulfils all the legal requirements and formal procedures necessary when dealing with a deceased
- The requirements of the Coroner are met.
- Clear identification of the responsibilities where it is not a doctor who verifies death.

Verification of Death

Definitions

Verification of death is defined as the clinical examination to determine whether a patient is actually deceased and does not require a practitioner to undertake this process.

Certification of death is the process of completing the "Medical Certificate of Cause of Death". This has to be done by a doctor who has attended the deceased in life.

Expected death – is defined when discussions have taken place between the patient and family and the medical and nursing team, regarding deterioration and the decision has been made and documented in the medical notes that no further intervention is appropriate.

Who can Verify a Death?

Medical practitioners and ACPs can verify any death, expected or unexpected.

Night Nurse Practitioners, Clinical Site Practitioners and RNs deemed competent, having completed the Trust scope document and working within their care setting, can verify expected deaths of all adults (over the age of 18) where the following conditions apply:

- Death is expected and not accompanied by any suspicious circumstances. This includes when the person has died expectedly from or with COVID-19
- An individualised conversation between the patient and a healthcare professional agreeing to the DNACPR decision has previously been undertaken and recorded in the patient's clinical notes
- Where the person is found deceased without a DNACPR conversation documented and there are signs of irreversible death (e.g. rigor mortis), verification of death can be carried out
- Death occurs in a private residence, hospice, residential home, nursing home, prison, or hospital
- Including where the patient dies under the Mental Health Act including Deprivation of Liberty Safeguards (DoLS).

RN exclusion criteria: Any expected adult death believed to have occurred in suspicious circumstances.

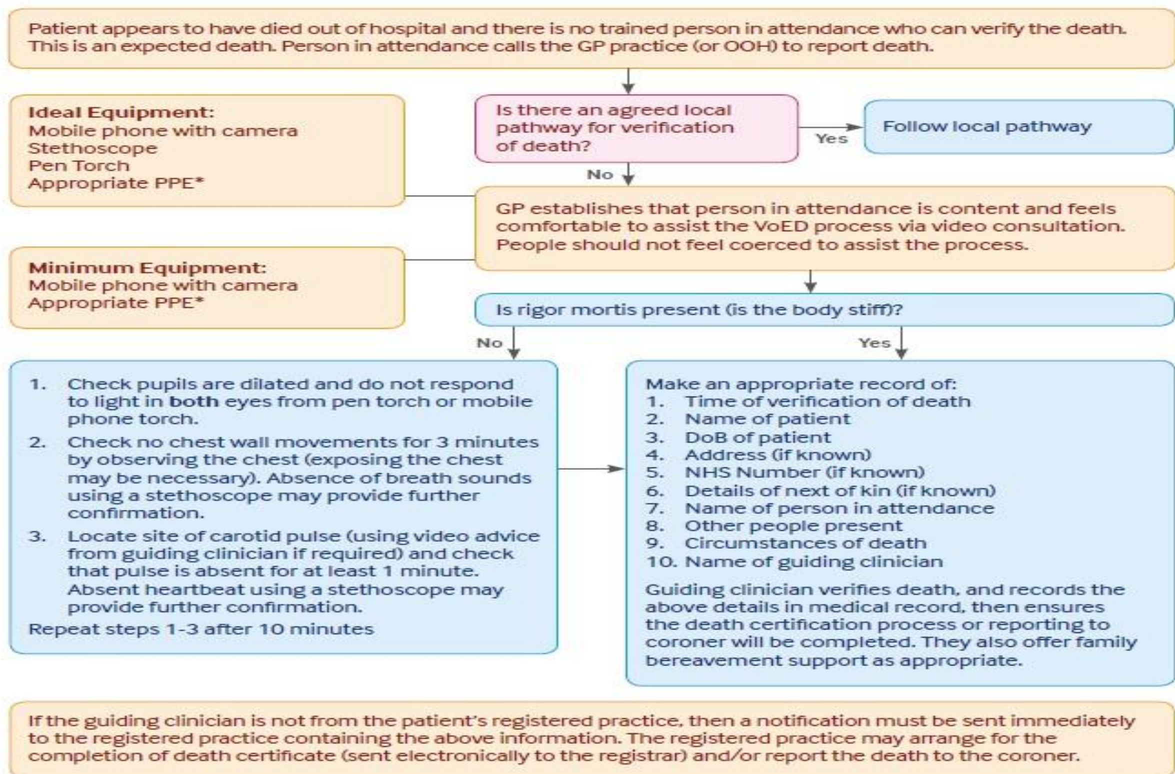
Verification of death must be recorded in the patient notes.

Remote Verification of Death Process – Community Hospitals

The following process for remote verification of death is in line with BMA guidance and is now 'normal' practice' in and out of hours.

This guidance is designed to provide remote support by people (such as care workers) who have not had training in verifying death so that the verification process can be completed by a clinician safely and speedily. If relatives / friends of the deceased wish to support the process before the undertaker arrives, care needs to be taken to ensure this is appropriate and conducted sensitively – no person should be asked to do anything they are uncomfortable with. If it is not possible to support the process remotely, then alternative verification methods will be needed. The clinician carrying out the procedure

must inform the undertaker of any notifiable disease or any equipment eg syringe driver, catheter or pacemaker in place.



Identification of the Patient

The patient must be clearly identified and their name, age, date of birth and hospital number must be checked with the health record and patient identity bracelet.

Observations to Confirm Death

Observations to confirm death at QHB are on a paper document with an additional note made on the Meditech V6 electronic system. At Derby sites please complete the confirmation of death form in Appendix 1.

In order to verify death the following must be checked (1 - 3 for at least one minute):

1. Absence of carotid pulse
2. Absence of heart sounds
3. Absence of signs of spontaneous respiration
4. Absence of reaction to painful stimuli
5. Fixed dilated pupils which do not react to light determined by shining torchlight into both eyes and observing for any change in shape or size.

This should be repeated 10 min later unless COVID-19 is confirmed or suspected but the individual must be observed to be in cardiorespiratory arrest for a minimum of 5 minutes.

Informing the Practitioner

Where a RN has verified a death an appropriate registered medical practitioner from the parent medical team must be informed of the patient's death as soon as possible. The patient's consultant should also be made aware at the earliest opportunity.

Time Scales to Achieve

GPs and other associated support groups, such as community midwives/district nurses/physiotherapists, should be informed of a patient death by telephone as soon as possible, but no later than 48 hours after the death occurs, or by the first working day following a weekend period – whichever is sooner.

A Confirmation of Death Form (Appendix 1) must be completed at the same time as notifying the relevant GP surgery, with details of the patient involved, time and date of death, the cause of death (if this has been verified), the time and date a call was made to the GP, along with recording the department and the individual names of whom the conversation took place between. Times recorded should be done so on a 24-hour clock basis.

In the case of an incident occurring out of hours or over public holidays, the patient notes must be retained by the department or ward in charge at the time of death, until such time it is possible to make a telephone call to notify the relevant GP surgery. At this point the Confirmation of Death Form MUST be applied to the front of the deceased's notes and the relevant information completed in full, making sure to accurately complete the date, time, along with all other required information.

It is recognised that on certain occasions, the doctor in charge of care may require the notes and they will therefore leave the ward/department prior to the first working day after a death. If this is unavoidable, it is the Senior Sister's responsibility to ensure that the correct details are retained within the department to allow the communication with primary care and associated support services to be completed by the first working day. The form should be applied to the notes prior to them leaving the ward, with all possible information filled in and a note beside the "within 24 hours" question to explain the reasons for not making the phone call. Once the communication has been made, the correspondence information should be recorded and forwarded to the Bereavement Office (BO) to allow the information to be updated, fully completed and scanned onto the system.

Viewing the Deceased in the Mortuary Out of Hours

Requests for adult viewings are not routinely performed outside of normal office hours because of the restricted mortuary service. It is desirable that viewings are delayed until the next working day wherever possible. This allows viewings to take place in a more supportive environment and for families to combine viewing with the visit to collect documentation particularly if they live a long distance away. However, all requests should be made via the Duty Sister who can contact the On-call Mortuary Technician who will respond sensitively.

There is not a mortuary at the Community Hospitals. Relatives who wish to view the deceased can make arrangements with the local funeral directors.

Release at the Request of the Family Out of Hours

Please refer to the guidance notes that are available on NET-I in respect of out of hours release and early release.**:**

5. Care of the Deceased

The care of a patient and family / carers following death is one of the most significant and

sensitive aspects of care. Care after death is essential to ensure a compassionate, respectful and dignified process which reflects best practice principles, and ensures that relatives/carers receive appropriate and timely information and support following their bereavement.

Informing Relative / Carer

The relative / carer of the deceased should be notified as soon as possible after confirmation of death if they are not present at the time of death. This notification should be performed by the member of staff deemed most suitable by the nurse in charge at the time. Professional discretion should be used when deciding at what time to inform a relative / carer of the patient's death.

Care after Death

Care after death is the care given to a deceased patient, which demonstrates respect for the dead and is focused on fulfilling religious and cultural beliefs as well as health and safety and legal requirements.

Care after death should be performed in accordance with the procedure in the Royal Marsden Manual. Advice on any spiritual, cultural or religious needs can be sought from the Chaplaincy Teams if required. Contact with the on call chaplain can be made via switchboard.

Prior to undertaking care after death please refer to the spiritual, cultural and religious, needs of the deceased.

Two people should participate in care after death, one of whom should be an experienced member of the clinical care team.

Invite the relative / carer to spend time with the deceased prior to undertaking care after death. It is best practice to ask a relative / carer of the deceased if they wish to assist in the care after death or be present during the procedure. Whenever possible the deceased should be left to rest before commencing this procedure.

It is important that staff or a relative / carer who may have to care for a deceased's body are protected from risk of infections due to exposure of pathogenic organisms. Standard infection control precautions, including effective hand hygiene, should be utilised at all time.

Washing and Dressing the Deceased

The deceased patient should be washed (unless requested not to do so for religious / cultural reasons) and dressed in a shroud.

If the relative/carer wishes the deceased person to wear their personal clothing during transfer to the Mortuary it is acceptable **EXCEPT** if the deceased patient will require a post mortem. The ward staff need not pre-arrange this with the Mortuary staff, but a note must be made in the 'comments' section of the Notice of Death form (Appendix 2).

If the deceased is to have a post mortem examination, for manual handling purposes, they must be placed in a shroud. It must also be noted that there is a risk of the clothing becoming soiled from leakage of body fluids following death. The relative / carer should be advised that this may occur.

Additional clothing must not be sent to the Mortuary with the patient as the Mortuary staff do not dress the deceased. Relatives / carers should be advised to take all clothing to the funeral director and their staff will dress the deceased.

Dentures

Dentures must be put in place as soon as possible after death as this is difficult for the Mortuary staff to do once rigor mortis has set in. If it is not possible for dentures to be left in place (i.e. an endotracheal tube is in situ), these should be placed in a denture pot labelled with a hospital identification label and sent to the Mortuary with the deceased.

This should be recorded on the Notice of Death Form in the comments box (Appendix 2).

Intravascular Cannulae, Intravenous Infusions and Central Lines

In all deaths in hospital, whether natural or otherwise, intravascular cannulae and lines must remain in situ. Removal of these lines may result in post mortem leakage of blood which can contaminate clothing/body coverings and generates unnecessary health risk for the Mortuary staff who then have to clean the body before viewing by relatives.

Any intravenous infusion should be disconnected and the cannula capped.

Long central lines should be capped and folded over and covered with an occlusive dressing.

The Mortuary staff must be informed of any item of medical equipment that is left attached to the body so that it is not accidentally removed nor causes any injury during handling of the body. This will be documented in the patient's health record.

Mortuary staff must also be informed if a patient has an implant of any kind including pacemakers and ICDs as this can be a serious health and safety risk if the body is for cremation.

Relatives must be informed in advance of any medical devices that are left attached to the body. Tubes and lines around the head and neck may be concealed or disguised by tape or bandages if this is felt to be appropriate.

Chest Drains, Surgical Drains, Epidural Lines

Chest drains, surgical drains, epidural lines etc. must remain in situ. They may be disconnected, capped and then folded back and covered with an occlusive dressing.

All tubes, drains, venous access lines left in place must be documented on the comments section of the Notice of Death form.

If the patient has a pacemaker or external prosthesis this must also be recorded.

Identification of the Deceased

The deceased must be positively identified and their name, age, date of birth and hospital number must be checked with the health record and patient identity bracelet.

Following care after death the patient must be identified with two identification bracelets, one attached to each wrist. On the rare occasion that the deceased has an upper limb

amputation, one identity bracelet should be applied to one wrist and the other to an ankle. If the deceased's limbs are excessively swollen two identification bracelets can be attached to make one large band.

The following information must be written in block capitals on each identification bracelet. Both bracelets must be clearly visible (i.e. not under the sleeve of the shroud):

- Deceased patient's full name
- Ward
- Hospital number
- Date of birth.

Handling of the Deceased's Property and Valuables

In accordance with the Trust Policy for Handling of Patient's Property and Valuables, all jewellery must be removed (in the presence of a colleague) unless requested by the patient's relative/carer to do otherwise.

Jewellery (including rings) must be lightly taped to secure them in place.

Jewellery remaining on the deceased should be clearly documented on the Notice of Death Form (Appendix 2).

A record of the jewellery and other valuables must be recorded in the patient's property book and the items stored according to the Trust's Policy for Handling of Patient's Property and Valuables.

Viewing within the Clinical Area

The deceased should be made presentable for relatives/carers to view should they wish, including ensuring the eyes and mouth are closed, limbs should be straightened if possible, but not bandaged. Explanations should be offered to relatives/carers if this cannot be completed.

The relative/carer should be offered the opportunity to spend time with the deceased patient before they are transferred out of the clinical area. The environment should be made as suitable and dignified as possible.

Pre-Transfer from the Clinical Area

The deceased must be prepared for transfer to the Mortuary, respecting the spiritual, cultural and religious wishes of the patient and relatives/carers.

The deceased must be placed in a non-zipped cadaver body bag that is closed with tape. Staples must not be used to secure the bag. The deceased should then be wrapped in a sheet ensuring that the face is fully covered.

Infected Deceased / Risk of Infection due to Leaking of Body Fluids

The deceased will pose no greater threat of an infection risk than when they were alive. Deceased who pose, or potentially pose an infection control risk, should be placed in a cadaver zipped body bag. Indiscriminate use of body bags may cause unnecessary anxiety for the bereaved family and friends and also amongst staff including portering staff. However, all cases known or suspected to be infected with any of the conditions listed below should be labelled 'High Risk' or 'Danger of Infection' and should be placed

in a sealed body bag before transporting the body, in order to minimise the risk of spread of infection.

Guideline for Handling Deceased with Notifiable Infections

Infection	Is a Sealed Cadaver Bag Required	Can the Body be Viewed
Anthrax	Yes	No
Cholera	Yes	Yes
Diphtheria	Yes	Yes
Dysentery	Yes	Yes
Food Poisoning	Yes	Yes
Hepatitis A	Yes	Yes
Hepatitis B, C and non-A non-B	Yes	Yes
Invasive Group A Streptococcus	Yes	Yes
Meningococcal septicaemia +/-	Yes	Yes
Paratyphoid fever	Yes	Yes
Plague	Yes	No
Rabies	Yes	No
Scarlet Fever	Yes	Yes
Smallpox	Yes	No
Tuberculosis	Yes	Yes
Typhoid Fever	Yes	Yes
Typhus	Yes	No
Viral Haemorrhagic Fever	Yes	No
Yellow Fever	Yes	No

Guidelines for Handling Deceased with Infections that are not Notifiable

Infection	Is a Sealed Cadaver Bag Required	Can the Body be Viewed
HIV / AIDS Haemorrhagic fever with renal syndrome Transmissible spongiform encephalopathy eg CJD	Yes No Yes	Yes Yes Yes

Deceased's who leak body fluids must also be placed in a zipped body bag. Wound dressings should be left in place. An occlusive dressing must be applied to leaking line insertion points. If there is an excessive quantity of exudate an incontinence pad can also be used over the top of the occlusive dressing.

Sleek must not be used, as it will cause damage to the skin on removal. Identity bracelets and any jewellery must be clearly visible through the bag.

Transfer to the Mortuary

After completion of all care and documentation the porters must be contacted to take the deceased to the Mortuary. It is advisable to remove the deceased from the ward within 4 hours. If the relative / carer wish to remain with the deceased patient during the transfer from bed to concealment trolley, the porters should be notified as soon as they arrive on the ward.

Whilst the deceased is being taken from the ward the curtains around adjacent patient's beds should be closed. Patients in adjacent beds should be given an explanation and offered support as needed.

If the patient is bariatric they must be transferred in the bariatric concealment trolley. Under no circumstances must patients be transferred from the ward to the mortuary on a bed

Viewing Arrangements in the Mortuary

During Working Hours:

Viewings normally take place between 10.00 – 15.45hrs, Monday to Thursday and 10.00 – 15.30hrs Fridays and always by prior arrangement with the Mortuary staff. Any relatives/carers wishing to view can contact the Mortuary directly or via the ward; BO or the Emergency Department staff who will contact the Mortuary staff on your behalf.

Outside Working Hours:

The Mortuary services operate an on-call system and a member of staff is available to conduct any viewings required out of hours. Any viewings outside normal working hours will only be carried out at the discretion of the on-call technician as their services are required for community deaths that occur out of hours. No viewings will be conducted after 21.00hrs unless under exceptional circumstances; ie in the case of sudden death when identification is required for continuity purposes. The on-call technician can be contacted via the hospital switchboard. Contact details of the on-call technician must not be passed on to relatives.

It is preferable that requests are delayed until the next working day wherever possible. This allows viewings to take place in more supportive environment, and for families to combine the viewing with their appointment to collect documentation from the BO, particularly if they live a long distance away.

If a relative / carer wish to view a loved one that has died in a community hospital, they will need to make an appointment by contacting the funeral director to arrange a visit to their chapel of rest at the funeral director.

6. Completion of MCCD

Legal Responsibility

It is a legal responsibility of attending doctors to complete a MCCD "to the best of his / her knowledge and belief" (see Appendix 4). This must be carried out promptly and efficiently as delays and errors may result in the funeral arrangements being delayed.

Certificates should ideally be completed with 24 hours of death or as soon as possible.

Data from MCCDs is used to code the cause of death using the International Classification of Diseases. Mortality statistics are based on a single cause of death.

The underlying cause of death is defined by the World Health Organisation (WHO) as:

- The disease or injury which started the events directly leading to death
- The accident or the violence that produced the fatal injury.

Mortality data is used for monitoring the health of the population, planning and evaluating health services and research (National Statistics Death Certification Advisory Group 2010).

Determining the Cause of Death

The determination of the cause of death is often difficult and advice may be necessary and should be discussed with the Consultant in charge of the case or the relevant covering Consultant. It is a matter of clinical judgement to decide whether a condition present at, or just before, death contributed to the patient's death.

Completing the MCCD

Cause of death the disease or condition thought to be the underlying cause should appear in the lowest completed line of part 1	
1	(a) disease or condition leading directly to death
	(b) other disease or condition, if any, leading to 1(a)
	(c) other disease or condition leading to 1(b)
2	Other significant conditions contributing to death but not Related to the disease or Condition causing it

Part 1

1a	Start with the immediate cause of death then go back through the events that led up to the death. If a single disease led to the death this should be entered in 1a and no other cause is necessary.
1b	Any other condition that led to the direct cause of death in 1a.
1c	Will have caused the conditions recorded in 1a and 1b. This is the section that shows the underlying cause of death and is the data that is used in Mortality statistics. This could be a chronic condition that predisposed to the fatal complications.

If necessary more than one condition can be added to one line.

If the patient had more than one disease and it is not clear which condition caused the death then all should be added on the certificate.

Deaths from infections must be included utilising the guidance. If there is no evidence of any specific disease which caused the death then the case should be referred to the Coroner.

Part 2

Any other disease, injury or condition that contributed to the death but was not the direct cause should be stated in this section.

Guidance Notes

If the cause of death is known but results of investigations are expected circle 2 on the front of the MCCD for post mortem information, or tick Box B on the back of the certificate

that investigations were initiated ante mortem.

- Do not use terminal events e.g. cardiac arrest or debility as they are not causes of death
- Do not use vague statements such as organ failure, natural causes
- Do not use abbreviations e.g. NSTEMI
- Do not use inappropriate English e.g. use haemorrhage not bleed
- Do not use CVA or cerebro-vascular accident
- Do not use old age as the direct cause of death in 1a, be specific and give relevant details if known
- Add the histological type and site of any cancer
- Specify insulin dependent or non-insulin dependent diabetes.

Deaths from Infections

In deaths from infectious disease include:

- The organism
- Antibiotic resistance if relevant
- The source and route of infection
- Pneumonia should include if lobar or bronchopneumonia, hypostatic or related to aspiration
- Add hospital or community acquired if known
- If associated with ventilation or invasive treatment.

Healthcare Associated Infections (HCAI)

Guidance for certifiers has clarified their responsibility under current legislation; in particular when patients have had an HCAI during their terminal illness. Doctors must include HCAIs on MCCDs where relevant.

Types of HCAI

The commonest HCAIs potentially related to the cause of death are Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. difficile), Extended Spectrum Beta – Lactamase positive (ESBL) and Escherichia Coli (E coli).

In some cases, there may not be documentation of microbiology test results within the clinical records and all relevant outstanding test results should be sought before issuing an MCCD.

If the doctor believes that C. difficile/MRSA or any other HCAI was the cause of death then this should be entered into Part 1 of the death certificate. If the patient's death was due to a different disease but the doctor believes that C. difficile/MRSA or any other HCAI was a contributing factor this should be entered into Part 2 of the death certificate.

However if the doctor believes that although C. difficile/MRSA or any other HCAI was present neither caused the death nor was a contributing factor, then there is no requirement to include it on the death certificate. If however, the family are unhappy with this, the case should be referred to the Coroner for adecision.

Determining the Cause of Death where there is a HCAI

Where HCAIs follow treatment, including surgery, radiotherapy, anti-neoplastic, immunosuppressive, antibiotic or other drug treatment for another disease, then it is

important to specify the treatment and disease for which treatment was given. Similarly, the sites or manifestation of any HCAI (e.g. wound, blood stream or gastro-intestinal infection) should be included together with the source or route of infection (e.g. healthcare or community acquired, device – associated, water or foodborn).

It should be remembered that there is a high carriage of some infective agents associated with HCAIs in the community and it is important to clearly identify the external source of these infections. HCAIs contracted in hospital should be clearly identified as such by the use of appropriate terminology, eg hospital acquired, before the specified type of infection.

7. Notification of Death to the Coroner

The Coroner is an independent judicial officer appointed by the Local Authority and has a duty to investigate any death that was violent, sudden or with an unknown cause.

It is the responsibility of the attending doctor to report any death that meets the criteria. In circumstances where the criteria are not clearly met advice should be sought from the Coroner's Office.

The Coroner will seek to establish the medical cause of death and may request a post mortem. If following this, the cause of death remains in doubt an inquest will be held.

There are certain categories of death which must be reported to the Coroner before the death can be registered

The Notification of Deaths Regulations 2019 require that a medical practitioner (who is registered with the GMC and has a licence to practice) MUST notify the Coroner where there is reasonable cause to suspect that the death was due to ie more than minimally, negligibly or trivially caused or contributed to by:

- Poisoning, including acute alcohol intoxication
- Exposure to a toxic substance
- The use of a medicinal product, controlled drug or psychoactive substances (which will include drug errors)
- Violence, trauma or injury
- Self-harm
- Neglect, including self-neglect. This will apply where there is reason to suspect that the death resulted from some human failure, including the acts / omissions of the clinicians involved in treating the deceased before they died
- Medical treatment or a procedure, which includes surgical, diagnostic or therapeutic procedures and investigations, nursing or any other kind of medical care and treatment that may have caused or contributed to the death. Deaths from a recognised complication of a procedure must be reported. Guidance accompanying the regulations also specifies that if a delayed diagnosis leads to an acceleration of death this must be reported to the Coroner
- An injury or disease attributable to any employment held by the person during their lifetime.

The statutory duty to notify also arises where:

- A doctor suspects that the death was unnatural
- The cause of death is unknown,
- The patient died whilst in custody or state detention (which includes detention under Mental Health legislation)

- When the doctor is unable to identify the deceased despite taking “reasonable steps” to do so.

Finally, it remains the case that the Coroner must be notified of a death unless a registered medical practitioner attended the deceased in their last illness AND has either seen the deceased in the 28 days prior to death or viewed the body after death.

The Coroner will advise if the doctor may issue an MCCD. The Coroner may tell the reporting doctor not to complete an MCCD which will then be issued by the Coroner following his investigation or post mortem.

Consultants have the overall responsibility for ensuring that referrals to the Coroner are made appropriately by members of their team. They must take a lead role to ensure that their teams raise all relevant issues with the Coroner who will then advise appropriately. The relevant Consultant must be informed by the reporting doctor of every death reported to the Coroner within a reasonabletimeframe.

For guidelines on the notification of deaths to the Coroner where there are safeguarding concerns please refer to Appendix 7 (Derby and Derbyshire Coroner’s Area Only)

Contacting the Coroner

Derbyshire Coroner

For the referral of deaths to the Derbyshire Coroner please use the portal below:

https://derbyshire-portal.coronersconnect.co.uk/

Staffordshire Coroner

For the referral of deaths to the Staffordshire Coroner please use the portal below:

https://coronersstaffordshireportal.icasework.com/form?Type=CorornersReferral&Login=False

Completion of Cremation Forms (Appendix 4 and 5)

Bereaved families have the legal right to inspect the completed Cremation Forms before a cremation takes place. Families can then draw the Medical Referee’s attention to any unexpected symptoms and discrepancies in the case.

Cremation Forms must be completed as soon as possible to minimise delays to funerals and further distress to bereaved relatives.

The Medical Referee – Crematoria

The Medical Referee is appointed by the Secretary of State for each Cremation Authority and must have been a registered Medical Practitioner for at least 5 years. He / she has the statutory power to authorise cremations following scrutiny of the Cremation forms.

The Medical Referee has the power under the Cremation Regulations (2008) to:

- Expect that evidence offered on the Cremation Forms shows sound clinical grounds for the cause of death

- Reject incomplete forms and may refuse to authorise a cremation until the forms are completed to his / her satisfaction
- Make any enquiry they consider necessary about the forms
- Refer a case to the Coroner where inspection of the Cremation Forms raises a possibility that the cause of death was not natural
- Order a postmortem.

Ensure that the doctors who complete Cremation Forms 4 and 5 (Appendix 4 and 5) are sufficiently independent of one another.

Cremation Forms – Principles

All sections of the forms must be completed and the Medical Referee may reject illegible forms. Abbreviations must not be used and the forms must be signed. The BO is authorised to reject incomplete or illegible forms.

A hospital inpatient should have a diagnosis that enables a specific cause of death to be written.

The Cremation Forms make it clear that it is a criminal offence under the Cremation Act (1902) to wilfully make a false statement in order to procure a cremation.

A copy of The Cremation (England and Wales) Regulations 2008 - Guidance for Medical Practitioners Completing Forms 4 and 5 (Ministry of Justice 2012) is available within the BO.

Legal Framework and Ministry of Justice Guidance for Medical Practitioners Regulation 16 of the Cremation (England and Wales) Regulations 2008 makes it clear that no cremation of the remains of a deceased person may take place unless a medical certificate and, subject to regulation 17(3), a confirmatory medical certificate are given in accordance with regulation 17(1) and (2) and respectively a certificate is given that the body of the deceased person has undergone an anatomical examination.

Cremation Form 4

Completion of Cremation Form 4 may only be undertaken by a registered qualified attending doctor.

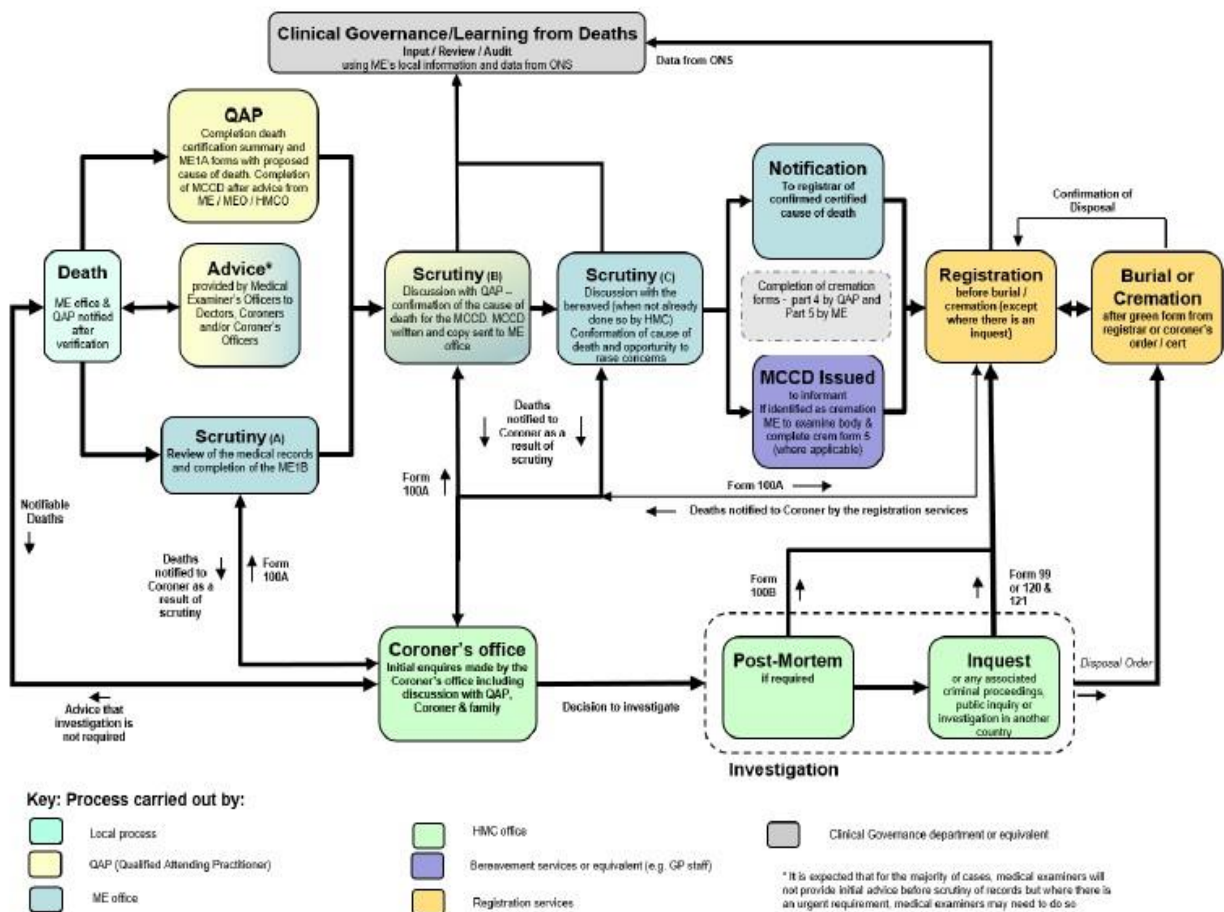
Completion is not part of a doctor's NHS contract, nor is it a statutory duty. Doctors completing Cremation Form 4 are paid a fee by the relevant funeral director and in doing so this becomes a private arrangement between the doctor and funeral director.

The requirements for the doctor signing form Cremation Form 4 include:

- Be registered (provisional or temporary is acceptable) with a licence to practise from the GMC
- Have treated the deceased during their last illness and have seen the deceased within 28 days of death
- Have cared for the patient before death or be present at the death. If that GP is unavailable, the coroner may agree to authorise a partner to sign the form
- Have examined the body after death.

It is acceptable for an FY1 or FY2 doctor or above to complete the Statement of Truth (Part 3) but the doctor's GMC Number must be added by any doctor completing the Statement of Truth regardless of grade.

- The doctor completing Cremation Form 4 must view and examine the body after death (alteration due to Coronavirus pandemic – viewing of body after death is not required)
- The doctor must not allow anyone to complete the form on their behalf. The Medical Referee will expect that evidence of sound clinical grounds for the cause of death are given. All questions must be answered and should include detailed information about the circumstances surrounding the death
- If there is any doubt as to the cause, sequence or mechanism of death the consultant in charge of the case MUST be informed and will advise prior to completion of the form
- The symptoms and other conditions section should be completed with the doctors observations in the period prior to death
- The cause of death should normally be the same as on the death certificate used to register the death and should show whether this was informed by the patient history, operations carried out or witness reports. Any operation which may have shortened the patient's life must be reported to the Coroner
- Any suspicious circumstances must be reported to the Coroner and the details recorded in the Health Records
- Any implants must be recorded on the form as they can cause a serious health and safety risk at the Crematorium
- The doctor signing Part 4 has a duty to confirm whether there are any hazardous implants within the body and confirm whether or not they have been removed.



Right of Inspection

The applicant for cremation has the right to request to inspect the cremation forms once the forms have been submitted to the Medical Referee. Some of the information on the

forms may have been given in confidence (particularly questions 9 and 10 on Cremation Form 4). If this would be a breach of confidence the information can be given to the Medical Referee on a separate sheet of paper attached to the form. This must include reasons for the omissions and that the information should not be disclosed to the applicant.

It is essential that the Cremation Forms are completed as soon as possible to facilitate any request for inspection in order to prevent any delay to the funeral.

It is not expected that there will be many applications as difficult cases will already have been referred to the Coroner and most applicants do not have concerns about the circumstances concerning death.

Deaths Where a Request for Rapid Release of the Deceased's Body is Made

Certain religious faiths specify specific timeframes for burial and / or cremation. The United Kingdom laws must be upheld even in such difficult circumstances. It is good practice that if a death is anticipated in a patient whose religious belief may require a rapid funeral process or removal of the body from the United Kingdom then this should be discussed with the family and BO in advance.

If it is known that the death will require referral to the Coroner advance discussions should again take place. The Coroner has indicated that provided a post mortem is not required that he may give permission for the body to leave the United Kingdom.

Procedure for Out of Hours MCCDs

Ordinarily if a patient dies after 16:00 hours on a weekday or at any time over a weekend or a Bank Holiday a MCCD will be issued the next working day.

These procedures do not apply in a case where a MCCD cannot be issued.

- If a patient dies Monday to Friday between 09:00 and 16:00 hours and in circumstances where a death certificate can be issued then a MCCD may be issued in the usual way
- If a patient dies any time from 16:00 hours Friday until 18:00 hours Sunday or on a Bank Holiday and in circumstances where a death MCCD can be issued, the doctor must carry out the following procedure:

  - Obtain MCCD box from Hospital out of Hours team in the Operations Centre
  - Complete MCCD
  - If discussion is needed with the Coroner, the doctor can contact the Coroner via the switchboard within the following times

    Saturday Sunday

    08:00 – 18:00 hours
    08:00 – 18:00 hours

- For patients dying after 18:00 hours on Friday night contact can be made Saturday morning
- For patients dying after 18:00 hours Saturday night contact can be made Sunday morning

- For patients dying after 18:00 hours Sunday night contact can be made Monday morning
- For patients dying on a Bank Holiday Monday after 18:00 hours contact can be made on the Tuesday morning.

Procedure when a Death has Occurred and Urgent Permission is Required to Take a Body out of England and Wales (Out of England Certificate).

The procedure shall be used where it is necessary for the Coroner to issue a certificate of Removal, and a Registrar of Births and Deaths to register a death on a Saturday, Sunday or Bank Holiday.

This procedure shall only be used in an emergency and if certain conditions are met. An emergency arises where the only flights available to carry the body to the required country are on one of the four days following the request for removal.

In order for this procedure to take effect, the following conditions MUST be met:

- The death must be due to natural causes and give the Coroner no reason to investigate further or require a post mortem examination
- The Coroner reserves the right to ask questions concerning the circumstances surrounding the death
- If he is not satisfied, he may delay the issue of a certificate of removal.

A doctor must be able to certify the cause of death. If the deceased had been attended to by a locum doctor, a MCCD will have to be obtained from the deceased's medical practitioner.

Where it is necessary under this procedure for the Coroner or the Superintendent Registrar of Births and Deaths (or their nominated representatives), to carry out their duties on a Saturday, Sunday or Bank Holiday, the funeral director or the Chairman of the Pakistan Muslim Funeral Committee shall liaise between the Coroner and the Registrar and the family of the deceased. Friends or relatives of the deceased MUST NOT contact the Coroner or Registrar direct.

By a Memorandum of understanding between the Islamic faith groups the Chairman has authority to act on behalf of the Islamic communities.

Procedure

- Upon a death occurring where the family of the deceased intend to take the body out of England and Wales, a member of the family and / or Chairman of the Committee will contact the funeral director
- The funeral director will check that a death certificate has been issued and deal with any arrangements associated with removing the body out of England and Wales
- The funeral director will contact the Coroner by telephone and notify him of the circumstances of the death and whether a death certificate has been issued
- The Coroner will decide whether he is willing to issue an urgent Certificate of Removal by waiving the prescribed four days' notice
- If the Coroner is willing to issue an urgent certificate, the funeral director will contact the on-call Registrar for Births and deaths to arrange for the Registrar to attend the Registrar Office to register the death and issue a certificate for disposal of thebody

- Under the provisions of the Registration Act a Registrar who is not satisfied with the circumstances of the death or the certificate contains errors he has the authority not to continue with the registration process and will notify the Coroner of his concerns
- If the Coroner and the Registrar are willing and able to issue the appropriate certificates, mutually convenient times will be arranged for.

A Registrar and a member of the family to attend the Registrar's Office and the funeral director to attend the Coroner's Office.

No more than three members of the family will attend the Registrar's Office with a Registrar for the purpose of registering the death. The registrar will require the following:

- MCCD
- Information about the date and place of birth of the deceased
- Informationregarding occupation
- The address of the deceased
- The exact fee must be paid to the Registrar in cash, cheque or card.

When the death has been registered and the Coroner has no issues with the authority to remove the body, the funeral director will be free to complete the arrangement for taking the body out of England and Wales. The funeral director will be supplied with the relevant telephone numbers for the Coroner, Deputy Coroner, Assistant Deputy Coroner and the Registrar, on the strict condition that he will not disclose them to any other person.

8. Monitoring Compliance and Effectiveness

Notification of Death to Coroner and Completion of Relevant Information

Monitoring will be carried out by the LFDG. The Group monitors Trust mortality data both retrospectively and prospectively identifying areas for concern.

The Group will agree the proposals for action plans including educational plans and monitor progress by exception and risks, escalating issues as required.

APPENDIX 1a

NHS University Hospitals of Derby and Burton NHS Foundation Trust

CONFIRMATION OF DEATH (RDH Site)

Patient's Surname:	Date: dd/mm/yyyy	Time:
Patient's other names:	Date of Birth (if known) or approximate age	
Patient's Home Address: Contact Telephone:	Location of death (if different from home address): Contact Telephone:	
Details of Patient's General Practitioner (GP)		
Name:	Contact Telephone:	
Address:		

Clinical Findings (please observe each for at least one minute)	**Please delete as appropriate**			
	Baseline		**Baseline + 10 minutes**	
Carotid pulse	Present	Absent	Present	Absent
Heart sounds	Present	Absent	Present	Absent
Signs of spontaneous respiration	Present	Absent	Present	Absent
Fixed dilated pupils	Present	Absent	Present	Absent
Reaction to painful stimuli (e.g. trapezium pinch)	Present	Absent	Present	Absent
Is there any immediate need to refer to the Coroner or Police?			Yes	No

Any Comments:

Name & collar number of any Police Officer already in attendance:

Prostheses: please specify if known (e.g. internal pacemakers, internal defibrillators, eyes etc.)

Confirmation of Death

Life verified extinct at:		hours	minutes	date (dd/mm/yyyy)
Confirmed by:	Name:	Signature:		Contact Telephone:
Witnessed by: (not essential)	Name:	Signature:		Contact Telephone
GP contacted by:			Time contacted: Date:	
Name of GP:		Contact Telephone:		
Relative contacted by:			Time contacted: Date:	
Name of relative:		Contact Telephone:		

Funeral Director/Undertaker:

Name:	Contact Telephone:	Body Collected at: Taken to:

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

CONFIRMATION OF DEATH (QHB Site Only)

For Use in Adults & Children

Date and time...

Doctor Name and Designation

Name...,........................,...

Signature..

Grade..

HOSPITAL ADDRESSOGRAPH or
Surname:
First Name:
Date of Birth:
Hospital Number:

Pre-Conditions of Diagnosis	
1. Areyousatisfied thereissimultaneous apnoea andunconsciousnessinthe absence of circulation?	Y / N
2. Are you satisfied there is no indication to commence / continue resuscitation?	Y / N
Diagnosis	
3. Have you observed for a minimum of 5 (five) minutes to establish that irreversible cardiorespiratory arrest has occurred?2	Y / N
4. Is there absence of central pulse on palpation and absence of heart sounds on auscultation ?	Y / N
5. In certain hospital settings these criteria can be supplemented by reference to ancillary monitoring modalities: • Asystole on continuous ECG display • Absence of pulsatile flow using direct intra-arterial pressure monitoring • Absence of contractile activity using echocardiography **If used do these modalities confirm an absence of the circulation?**	Y / N / Not Used
6. Is there absence of the pupillary response to light?	Y / N
7. Is there an absent corneal reflex?	Y / N
8. Is there an absent motor response when supraorbital pressure is applied?	Y / N
Complications of Diagnosis	
Are you satisfied that death has been confirmed following cardiorespiratory arrest?	Y / N
The time of death Is recorded at the time at which these criteria are fulfilled. (Record this in patient record in addition to this form)	**Date:** **Time:**
Is there an indication to refer this case to HM Coroner? Please elaborate if yes:	Y / N / Unsure
Is there an indication for a hospital post-mortem examination? Please elaborate if yes: **All patients canbe considered for tissue donation. Check the Organ Donor Register on 01179757S80 and Page Tissue Services on 0800 4320559 for further advice.**	Y / N / Unsure
Please give the full name(s) of the nurse(s) present at the moment of death? .... Please give the full name of any other person present at the moment of death?	
Did any person present at the time of death express any concern regarding the cause of death?	Y / N / Don't Know

Notes

1. Contributory causes to the cardiorespiratory arrest (eg. hypothermia s34"C, endocrine, metabolic or biochemical abnormality) should be considered and treated, if appropriate, prior to diagnosing death.
2. 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.

CAUSE OF DEATH: *(Responsible consultant to complete)*

1a ____

1b ____

1c ____

2 ____

Coroner to be informed: Yes / No:

(ie. Fall, surgery in last 12 months, MRSA, CDiff, industrial cause)

GP IMFORMED : *(ward clerk or in absence of ward clerk nurse in charge to complete)*

Date & timeinformed GP by phone: ______________________________

Within 48 hours: Yes / No

If No reason: ______________________________

Informed (name of person GP surgery): ______________________________

Informed by (name of person BHFT): ______________________________

DEATH CERTIFICATE COMPLETED: Yes/No

(Any doctor in team who treated patient within last 14 days to complete medical certificate in Bereavement office as soon as possible to avoid delays for family)

Certificate completed by______________________________*signature of doctor*

______________________________Print Name

______________________________GMC number

Date completed: ______________________________

If spoke to coroner outcome of conversation

____

____

____

BEREAVEMENT SERVICES checked all above are complete, spoke to family and scanned on V6: *(Completed by Bereavement Services staff)*

Signature:____________________Name:____________________Date: __________

University Hospitals of Derby and Burton NHS Foundation Trust

NOTICE OF DEATH

Details of Deceased

Hospital Number:______________________ Ward/Department:__________RDH/QHB/LRCH

Surname:_____________________________ Date of Birth:______________Age:________Yrs

First Name:___________________________ Religion: ______________________

Date death verified on:_______20____By:____________________Designation:_______at____hrs

Details of Medical practitioners

Consultant Name:______________________ Consultant Initials:____________________________

Name of Doctor (F1/F2):________________ Grade:_____________Bleep Number:____________

Details of Medical Intervention

Please record any equipment left in situ. e.g. ET Tubes, CVP lines etc.

....

....

....

Identification and Preparation

Does the deceased have two identification bracelets in place? YES ☐

Please Note:

The information on the ID bracelets must include: Full Name, Ward, Hospital Number and Date of Birth.

Is the patient dressed in a shroud YES ☐

Is the patient placed in a non-zipped bag YES ☐ (or) Cadaver zipped bag YES ☐

Property:

Please list ALL Jewellery left on the patient

Does the patient have a Pacemaker? Yes / No

Please list all external prosthetics:

Other Comments:

Risk of Infection: **Yes / No**

Please give details of any infection risk:

The Trust Infection Control Policy must be adhered to when preparing the deceased for transport to the Mortuary Department.

Details of the Person Completing the Above Information

Print Name:_______________ Designation:_____________Ext No: ____________

Date:___/__/_______ Time:________ Signature: ___________________________________

For Mortuary Use Only:

Identification Checked: YES/NO Property Checked: YES/NO

Date: / / Signature:

Distribution white copy to be attached to the body, Blue copy to Histopathology, Green copy to remain with notes

)

Medical certificate

Cremation 4
replacing Form B

01.0

This form can only be completed by a registered medical practitioner.
Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 Details of the deceased

Full name

Address

Occupation or last occupation if retired or not in work at the date of death

Where a past occupation of the deceased person may suggest that the death was due to industrial disease, you should consider whether to refer the death to a coroner.

Part 2 The report on the deceased

1. What was the date and time of death of the deceased? Date / / Tim

2. Please give the address where the deceased died. Address

Please state whether it was the residence of the deceased or a hotel, hospital, or nursing home etc.

- ☐ Their home
- ☐ Hospital
- ☐ Other (please specify)
- ☐ Hotel
- ☐ Nursing home

Part 2 continued

3. Are you a relative of the deceased? ☐ Yes ☐ No

   If Yes, please give the nature of your relationship.

4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? ☐ Yes ☐ No
   If Yes, please give details.

5. Were you the deceased's usual medical practitioner? ☐ Yes ☐ No

   If Yes, please state for how long.

   If No, please give details of your medical role in relation to the deceased.

6. Please state for how long you attended the deceased during their last illness?

7. Please state the number of days and hours before the deceased's death that you last saw them alive?

   Days ______________ Hours ______________

8. Please state the date and time that you saw the body of the deceased and the examination that you made of the body.

   Date / /

   Time

   Examination

Part 2 continued

9. From your medical notes, and the observations of yourself and others immediatelybefore and at the time of the deceased's death, please describe

the symptoms and other conditions which led to your conclusions about the cause of death.

10. If the deceased died in a hospital at which they were an in-patient, has a hospital post-mortem examination been made or supervised by aregistered medical practitioner of at least five years' standing who is neither a relative of the deceased nor a relative of yours or a partner or colleague in the same practice or clinical team as you? ☐ Yes ☐ No

If Yes, are the results of that examination known to you? ☐ Yes ☐ No

Note: 'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I. 2002/3135) has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

Part 2 continued

11. Please give the cause of death

1. (a) Disease or condition directly leading to death (this does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc: it means the disease, injury, or complication which caused death)

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any, leading to (b)

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

12. Did the deceased undergo any operation in the year before their death? ☐ Yes ☐ No

If Yes, what was the date and nature of the operation and who performed it.

Date of operation / /

Who performed it

Nature of operation

13. Do you have any reason to believe that the operation(s) shortened the life of the deceased? ☐ Yes ☐ No

If Yes, please give details.

Part 2 continued

14. Please give the full name and address details of any person who nursed the deceased during their last illness (Say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death.)

15. Were there any persons present at the moment of death? ☐ Yes ☐ No

    If Yes, please give the full name and address details of those persons and whether you have spoken to them about the death.

16. If there were persons present at the moment of death, did those persons have any concerns regarding the cause of death? ☐ Yes ☐ No

    If Yes, please give details

17. In view of your knowledge of the deceased's habits and constitution do you have any doubts whatever about the character of the disease or condition which led to the death? ☐ Yes ☐ No

18. Have you any reason to suspect that the death of the deceased was

Violent	☐ Yes	☐ No
Unnatural	☐ Yes	☐ No

19. Have you any reason at all to suppose a further examination of the body is desirable? ☐ Yes ☐ No

    If you have answered Yes to questions 17, 18 or 19 please give details below:

Part 2 continued

20. Has a coroner been informed about the death? ☐ Yes ☐ No

If Yes, please state the outcome.

21. Has there been any discussion with a coroner's office about the death of the deceased? ☐ Yes ☐ No

If Yes, please state the coroner's office that was contacted and the outcome of the discussions.

22. Have you given the certificate required for registration of death? ☐ Yes ☐ No

If No, please give the full name and contact details of the medical practitioner who has

Full name

Address

Telephone number

23. Was any hazardous implant placed in the body (e.g. a pacemaker, radioactive device or 'Fixion' intramedullary nailing system)? ☐ Yes ☐ No

Implants may damage cremation equipment if not removed from the body of the deceased before cremation and some radioactive treatments may endanger the health of crematorium staff.

If Yes, has it been removed? ☐ Yes ☐ No

I certify that I am a registered medical practitioner.

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name ____

Address ________________________ Telephone number ____________

Registered qualifications ________________________________

GMC Reference number ________________________________

Signed ________________________ Dated __ / /

Once completed, this certificate must be handed or sent in a closed envelope by, or on behalf of, the medical practitioner who signs it to the medical practitioner who is to give the confirmatory medical certificate except in a case where question 10 is answered in the affirmative, in which case the certificate must be so handed or sent to the medical referee at the cremation authority at which the cremation is to take place.

01.0

Appendix 5

Cremation 5
replacing Form C

Confirmatory medical certificate

This form may only be completed by a registered medical practitioner of at least five years' standing who is not either a relative of the deceased, the medical practitioner who issued the medical certificate (form Cremation 4) or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who issued that certificate.

'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I. 2002/3135) has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 Details of the deceased

Full name

Address

Occupation or last occupation if retired or not in work at the date of death

Part 2 The report on the deceased

1. Have you questioned the medical practitioner who gave the Medical Certificate (form Cremation 4)? ☐ Yes ☐ No

If No, please give reasons.

In answer to questions 2, 3, 4, and 5, please give names and addresses of persons questioned and say whether you spoke to them in person or by telephone. Any failure to answer one of these questions in the affirmative may be treated as inadequate enquiry.

2. Have you questioned any other medical practitioner who attended the deceased? ☐ Yes ☐ No

If Yes, please give the full name and address details of the medical practitioner(s).

3. Have you questioned any person who nursed the deceased during their last illness, or who was present at the death? ☐ Yes ☐ No

If Yes, please give the full name and address details.

4. Have you questioned any of the relatives of the deceased? ☐ Yes ☐ No

If Yes, please give the full name and address details.

5. Have you questioned any other person? ☐ Yes ☐ No

If Yes, please give the full name and address details.

6. Please state the date and time that you saw the body of the deceased and the examination that you made of the body.

Date / /

Time

Examination

7. Do you agree with the cause of death given in question 11 of Part 2 of the Medical Certificate (form Cremation 4)? ☐ Yes ☐ No

If No, please give reasons and give the cause of death.

Reason(s) for disagreeing

1. (a) Disease or condition directly leading to death (this does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc: it means the disease, injury, or complication which caused death)

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any, leading to (b)

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

Part 3 **Statement of truth**

I certify that I am a registered medical practitioner of at least five years' standing and I am not a relative of the deceased, or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who has given the Medical Certificate (form Cremation 4).

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name ______________________________

Address ______________________ Telephone number ______________

Registered qualifications ______________________________

GMC reference number ______________________________

Signed

Dated / /

Once completed, this certificate and the Medical Certificate (form Cremation 4) must be handed or sent in a closed envelope by one of the medical practitioners giving the certificates to the medical referee at the cremation authority at which the cremation is to take place.

BODY DONATON FOLLOWING DEATH

Human bodies are used to teach students about the structure of the body and how it works. They may also be used to train surgeons and other health professionals. These donations are highly valued at anatomical establishments.

The Human Tissue Authority (HTA) is responsible for the licensing and inspection of organisations, such as medical schools, that store and use human tissue. Human bodies are used to teach students about the structure of the body and how it works. They may also be used to train surgeons and other health professionals and can also be used for research.

Under the Human Tissue Act (2004) individuals must give written and witnessed consent for anatomical examination of their body PRIOR to death. Consent cannot be given by anyone else following their death.

A consent form is obtained from the relevant Medical School and close family or friends and the GP should be informed of the intended donation.

A donated body can be used for a number of reasons:

- Anatomical examination
- Research
- Education and training

Limitations to Body Donation

Certain medical conditions may lead to an offer of a body donation being declined. Details of these conditions can be obtained from the relevant medical school.

Patients on the Donor Register

Despite being separate donation systems it is possible for a person to be registered as an organ donor and to have registered their wish to donate their body, after death, to a medical school.

Medical schools will usually decline a body donation following surgery to remove organs for transplant. However, if the organs are unsuitable for donation then body donation can be taken forward by the relatives or executor of the deceased's will.

Funeral or Memorial Services

Medical schools will usually arrange for a body to be cremated unless the family requests that the body be returned for a private burial or cremation.

Payment and Costs

The individual will not receive any payment for the donation of their body.

There may also be a request to the family for a contribution to the cost of transporting the body, particularly if the medical school is out of the area where the death occurs.

Brain Donation

Scientists study brain tissue in their research to improve their understanding of how diseases start and progress e.g. Parkinson's and Alzheimer's disease. It is also important from deceased individuals who do not have any disease for comparison to study healthy brain tissue.

The Human Tissue Authority (HTA) licences organisations that store human tissue, including brains, for research. The HTA ensures that removal and storage is carried out appropriately and ensures that the wishes of deceased patients and their families is respected.

Further information is available on the Human Tissue Authority website on: www.hta.gov.uk

Appendix 7

OFFICE OF HER MAJESTY'S CORONER
DERBY AND DERBYSHIRE CORONER'S AREA

GUIDELINES ON NOTIFICATION OF DEATHS TO THE CORONER WHERE THERE ARE SAFEGUARDING CONCERNS.

February 2022 **Version 1.**

Introduction:

1.A number of deaths occur where there are in life safeguarding concerns relating to the deceased, whether the deceased is a child or adult.

2. The aim of this guidance is to assist professionals involved in safeguarding to appreciate the role of the coroner, coronial process, and notification to the coroner.

The Law:

3. A coroner has a duty to investigate a death (sections 1(1) and 1(2) Coroners and Justice Act 2009) where the body of the deceased lies within the coroner's area and the coroner has **reason to suspect that**:

a. The cause of death is unknown, or
b. The deceased died a violent or unnatural death, or
c. The deceased died in custody or otherwise in state detention.

Violent or Unnatural Death:

4. A violent death occurs when there is trauma or injury to the body which has either caused or more than minimally contributed to the death. For example, a fall resulting in a head injury causing death.

5. The injury or trauma does not have to be physical but can be a chemical injury. For example, the administration of medication which caused liver or kidney failure, resulting in death.

6. An unnatural death occurs where there is a culpable human failing that has made an otherwise natural death from natural causes unnatural. For example, an elderly woman in a care home develops a fever, shortness of breath and a chesty productive cough and dies of pneumonia. The cause of death is natural causes (the pneumonia), however, her death would be unnatural if the care home staff failed to summon a doctor or obtain medical attention, and that failure caused or contributed to her death.

Reason to Suspect:

7. A corner only needs to have a reason to suspect that the death is violent or unnatural. This

is a very low threshold. A coroner at this stage does not require any evidence or proof that the death was unnatural. If a coroner has reason to suspect that it was so, then he must begin an investigation into the death as a statutory duty.

8. A coroner may make whatever enquiries seem necessary in order to decide whether his duty to commence an investigation arises, (section 1(7)(a) Coroners and Justice Act 2009).

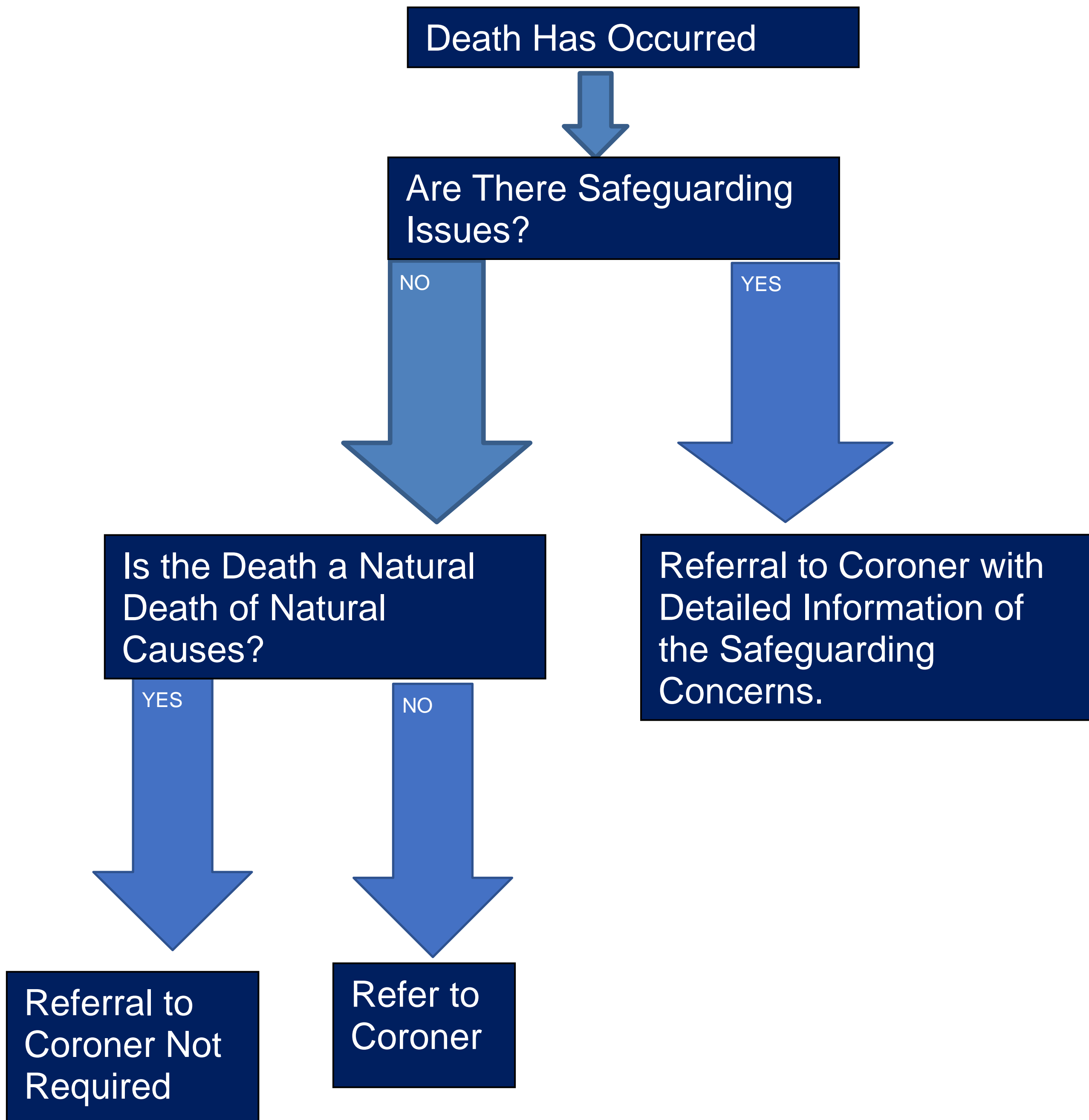
9. The decision to commence an investigation is a judicial decision made by the coroner. It is for the coroner to decide whether the safeguarding issue has caused or more than minimally contributed to the death. No other person can make that decision.

10. Consequently, the coroner should be notified of all deaths where safeguarding issues exist.

10. In order to decide whether an investigation and or inquest is necessary, a coroner must, from the start, have detailed information regarding the safeguarding issues.

11. As part of the investigation or inquest the coroner must receive a copy of the full and unredacted report of any safeguarding investigation that has taken place.

Flow Chart Notifying the Coroner of a Death



Safeguarding Concerns Identified After Funeral

12. There will be occasions where safeguarding concerns have been identified after a funeral has taken place. In most of such cases the coroner will not have been notified of the death.

13. In such circumstances the coroner should be informed of the death and the safeguarding concerns.

Actions of the Coroner on Receipt of Notification

Burial:

14. If the deceased has been buried the coroner can commence an investigation into the death. If the safeguarding concerns suggest a crime has been committed in respect of the death the coroner may order an exhumation of the deceased to enable a post mortem examination to take place.

Cremation:

15. If the deceased has been cremated the coroner can apply to the Chief Coroner of England and Wales to commence an investigation into the death in circumstances where the body has been destroyed, lost or absent.

Contact Details:

Derby Coroner's Office:

Tel: 01629 535050

e-mail: derby.coroner@derbyshire.gov.uk

Chesterfield Coroner's Office:

Tel: 01629 533405

e-mail: chesterfield.coroner@derbyshire.gov.uk

Robert W Hunter
HM Senior Coroner **8 February 2022**