



Care after Death

(Fourth Edition)

Guidance for staff responsible for care after death



National
Nurse Consultant Group
Palliative Care



Royal College
of Nursing



The Royal College of Pathologists
Pathology: the science behind the cure

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Foreword

We welcome readers across the four nations to this fourth edition of “Care after death: guidance for staff responsible for care after death”.

The need to give personalised compassionate care does not end when the person has died but continues with care after death, including supporting friends and families into bereavement. We recognise that each death is a uniquely individual experience that reflects many aspects, such as the illness the person has experienced, their personal preferences if a preference could be expressed, and the social, cultural, spiritual, and religious aspects of the person’s life.

It is 18 months since the third edition of the guidance was published to reflect the care required subsequent to the arrival of COVID-19. Now the illness is endemic this fourth edition reflects our learning and updated relevant guidance. We have also sought to ensure joint working with all those involved in the care of the deceased (including faith, spiritual and cultural leaders), the provision of bereavement services, and funeral directors.

We thank all the individuals representing organisations who have contributed so willingly and helpfully to this guidance and we look forward to continuing to work with you to keep this guidance current. We would recommend that commissioners of education and services consider the importance of this guidance in ensuring compassionate care for those who have died and those who are bereaved. This is even more important as we face a future with COVID-19.

In the future months we, Hospice UK and the National Nurse Consultant Group [Palliative Care], look forward to new working with the Academy of Medical Royal Colleges Task and Finish group to revise the Code of Practice for the Diagnosis and Confirmation of Death and will update this guidance again once there has been progress.

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Glossary

Bariatric – a person who requires non-standard equipment for moving, handling, and transferring due to their weight, physical size, shape or width.

Care after death – a term used in place of 'last offices' and more befitting of our multi-cultural society, reflecting the variety of tasks of care at the time of death, including supporting the family and those identified as being of most importance to the deceased.

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

Coroner – independent judicial officer appointed by local authority in England, Wales or Northern Ireland to investigate the cause and circumstance of a death. This includes where there is reasonable suspicion the death was violent or unnatural, or cause of death is unknown, or the death occurred whilst in custody or state detention, or the deceased was not seen by a doctor in the 28 days before they died.

Debrief – post-incident opportunity to discuss the event with support from another colleague or as a team, which provides the chance to talk about the emotional impact of the incident.

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

Expected death - An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. It is anticipated in the circumstances where advance care planning and the consideration of DNACPR will have taken place. The death can be verified even if the doctor has not seen the patient in the previous 28 days. Confirmed or suspected COVID-19 does not by itself make the death sudden or unexpected; but could if the death was considered unexpected.

Family Liaison Officer (in Prison) – supports key contacts with help to obtain answers to their questions regarding the circumstances of a death in prison and provides a clear point of contact with the Ombudsman's office.

Fixion nail - a self-locking expandable intramedullary nail system requiring no screws or fixings, commonly used to pin together bones that have been fractured. Once in place, the nail is expanded to lock hydraulically. There is a risk of explosion during cremation. The

presence of a fixation nail should be in the patient notes. However, it is the responsibility of the doctor completing the cremation form 4 to notify of fixation nails. The mortuary team are not trained in their removal, so as long as the funeral directors are made aware prior to cremation, this should suffice.

Implantable cardiac defibrillator – a device indwelling in the chest that delivers a therapeutic dose of electrical energy to a heart affected by an arrhythmia.

Key contact – a person identified as the central individual to communicate with. This could be a power of attorney for health and welfare, or a court appointed deputy, or an Independent Mental Capacity Advocate (IMCA). It could also be, for example, a husband, wife, son, or daughter; or a significant other, for example, a partner, friend, or neighbour.

Medical Certificate of the Cause of Death (MCCD) – a document given to key contacts to enable them to register the death and obtain the death certificate.

Medical Examiner – Senior medical doctor trained in legal and clinical elements of the death certification process. Appointed in England or Wales to be independent of the case when undertaking scrutiny of the circumstances of death.

Medical Examiner Officer – Supports the medical examiner in their role in scrutinising the circumstances and causes of death, and is a point of contact and source of advice for relatives of the deceased, healthcare professionals and coroner and registration services

Nursing Associate (NA) – a member of the nursing team (Band 4) who undertakes a nursing support role, provides care and support to patients and service users. Regulated in England by the Nursing and Midwifery Council (NMC) since July 2018.

Personal care after death – the physical preparation of the deceased after death and before transfer to the mortuary or funeral director.

Personal Protective Equipment (PPE) – PPE is equipment that will protect the user against health or safety risks at work including risks posed by micro-organisms including COVID-19. It includes disposable gloves, apron and surgical masks, and for aerosol generating procedures (AGP), includes eye protection, gowns and shoe protection too. Worn correctly and used in conjunction with other practices such as hand hygiene and risk assessment PPE reduces the risk of infection to the wearer.

Procurator Fiscal - appointed by the Crown Office & Procurator Fiscal Service (COPFS) in Scotland to investigate sudden, suspicious or unexplained deaths. Acts on instructions of the

Lord Advocate who has the responsibility in Scotland to investigate any death which requires further explanation.

Registered Nurse (RN) – a Registered Nurse who holds a valid registration with the Nursing and Midwifery Council (NMC) on the relevant part of the register.

Schwartz rounds - provides a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare¹. The purpose is to understand the challenges and rewards of providing care, not for solving problems, instead for providing staff with support and role model compassion².

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

Sudden or unexpected death - An unexpected death is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present, there is an expectation that resuscitation will commence³.

There is further clear guidance from the Resuscitation Council UK for circumstances where a patient is discovered dead and there are signs of irreversible death⁴. In such circumstances, the RN may make an informed clinical judgement not to commence CPR, for example clear signs of rigor mortis. The RN must be able to articulate and document clearly their actions and reasoning. There is new guidance from the Resuscitation Council UK in relation to CPR on suspected or confirmed COVID-19 patients, including the use of PPE and managing airways: 'PPE, including face mask and eye protection should be worn when carrying out resuscitation, and mouth-to-mouth or pocket mask airways management should not be undertaken. An oxygen mask, cloth or towel (depending on what is available) should be placed over the person's face to help reduce possible air contamination'⁵.

Introduction

1. This guidance is written to support the care of the deceased adult. There is concurrent guidance available for the care of the deceased child^{6 7} and for the death of a baby⁸. Staff providing the care of the deceased in all settings, including in the deceased's own home, will require clear guidance, training, and PPE to protect them whilst providing the care⁹. This guidance has relevance to all four nations (England, Wales, Scotland, and Northern Ireland) and respects both individual law and the evolution of clinical practice¹⁰. However, there is recognition that each of the four nations may need to tailor the guidance.
2. The care we provide to people who have died has never been more important. With some restricted visiting of the dying¹¹ and viewing of the deceased¹² in hospitals, hospices and care homes, those dear to the deceased who have not been able to visit will require additional reassurance that all has been done to care for the dying and deceased, and to maintain their dignity. Staff will need to continue to use resourceful ways to meet the information, emotional and practical needs of the immediately bereaved, and these may be via the use of remote technology¹³. Staff will be expected to work in cross-organisational teams to support individuals who have specific communication needs, for example, the needs of children, young people, those with dementia or learning difficulties. Individuals should also be aware of local resources available to support both communication and key contacts. National resources exist to support this aspect of care¹⁴. We recognise that competence to care for the deceased and support of their key contacts must be included in all training programmes, and we actively encourage this.
3. The guidance relates to other concurrent work:
 - Previous edition of the Care after Death guidance¹⁵
 - 5TH Edition Registered Nurse Verification of Expected Adult Death¹⁶
 - Academy of Medical Royal Colleges: code of practice for the diagnosis and confirmation of death¹⁷
 - Reforming the Coroner and Death Certification Service¹⁸
 - National Medical Examiners good practice guidelines (England and Wales)¹⁹
 - Death Certification Review Service (Scotland)²⁰
 - Leadership Alliance for the Care of Dying People – One chance to get it right²¹
 - Bereaved families' experiences of organ and tissue donation, and perceived influences on their decision-making²²
 - COVID-19 related infection prevention and control²³

- Handling The Deceased with Suspected or Confirmed COVID - 19 ²⁴
 - COVID-19: Guidance on dealing with patient-returned or unwanted medicines (England)²⁵
 - Coronavirus act expiry: Death certification and registration easements from 25 March 2022
4. There is a trend for more people dying outside the acute Trust, in their own home, (e.g. in care homes, private residences) and in institutions, (e.g. hospices, prisons and mental health settings). Whilst the effect of COVID-19 on the place of death is still to be fully evaluated, there is no doubt that staff in all care settings need to be familiar with this aspect of care.
 5. In this document the term 'key contact' is used and represents family and those people identified as being of most importance to the dying/deceased person. The shortened version is used for brevity and ease of reading. In line with the Mental Capacity Act 2005, the legal role given to people holding a Lasting Power of Attorney for health and wellbeing (LPA) is recognised. With respect to organ and tissue donation, medical practitioners should make every effort to establish the decision of the potential donor during his or her lifetime and support the fulfilment of this decision.
 6. Deceased organ donation in the UK currently only occurs in intensive care units and, to a much lesser extent, in emergency departments. In 2019 there were approximately 1600 organ donations and 3000 tissue donations compared to approximately 500,000 deaths²⁶. In England and Wales, adults who have not opted in or out of donation can have their consent deemed^{27 28}. At the time of publication, deemed consent legislation has gained Royal Assent in Northern Ireland but will not commence until Spring 2023. With post-mortem examination, consent needs to be sought, unless the post-mortem examination is authorised by the coroner in England, Northern Ireland and Wales, and procurator fiscal in Scotland, where consent is not required²⁹.
 7. The term 'deceased' is used to represent the deceased person and 'viewing' is used to represent the visiting of the deceased person by their key contacts. The shortened version is used only for brevity and ease of reading. The importance of personalising care is recognised. It is also noted that the same words can mean different things to professionals and key contacts. We urge professionals to use language that is meaningful to key contacts.
 8. It is also recognised that medical colleagues use the term 'confirmation of death'³⁰ rather than 'verification of death', as we have used in this document and related guidance³¹. We also note that our medical colleagues find the term 'confirmation' helpful when discussing

the recognition of death with families particularly in the context of organ donation³². We look forward to working with our medical and wider multi-disciplinary colleagues as discussed³³ to agree both the processes for verifying death in all clinical circumstances and the terminology. We note that Scotland has already moved to the term 'confirmation of death'³⁴.

9. The flow diagram in Appendix 1 is intended as both a summary and for teaching purposes. It shows that care after death (including personal care after death) is the first stage of a process that involves a range of professional groups. This process of care leads ultimately to cremation, burial, or repatriation of the deceased. Professionals involved in care after death include doctors, nurses, healthcare assistants, mortuary staff, hospital porters, ambulance staff, bereavement officers, specialist liaison workers, for example, those who support individuals with learning disabilities and their key contacts, police, social care staff, funeral directors, pathologists, coroners, procurators fiscal, healthcare chaplains and faith leaders. Coordinated working between these individuals and organisations is vital if the process is to run smoothly. The family, and those people identified as being of most importance to the deceased person, are the only people who navigate this entire process. We urge professionals to be both mindful of all steps in the process, and their part in the coordination of care to benefit the bereaved experience of care after death.
10. When a person dies an expected death, in their own home without family or a key contact, it is vital that care agencies understand the role they play in place of the family, or key contact. This is regardless of whether the care agency is funded by the NHS, Social care or privately. There is a responsibility to ensure that the appropriate professional is called to verify the death, the GP practice is notified so they can arrange the issuing of the MCCD, the deceased's dignity is maintained, the property is secured and there is a presence with the deceased until the funeral director can collect them. This does not need to be the care agency but adequate arrangements must be made prior to leaving the deceased.
11. When a person dies and they have no known family or they are unclaimed by their relatives and/or they have no remaining estate to pay for a funeral, they are entitled to a public health funeral of burial or cremation. In the UK, every local authority has a statutory duty to provide appropriate funeral arrangements³⁵. The local authority will endeavor to contact the person's closest relatives through any contact details or paperwork left by the deceased. There is also a nationwide tracing service and the Salvation Army can also attempt to identify lost relatives³⁶.
12. Whilst care after death in the community is usually undertaken by key contacts, it is important

for staff to understand the role of community nursing and palliative care teams in supporting key contacts during this time, as appropriate. Some cultures may have people from their local faith community attend and help wash and prepare the deceased. Some key contacts may utilise the services of a death doula³⁷, a non-medical professional who makes themselves available to the key contacts for support before, during and after a person's death. These people must be aware of the Public Health advice on infection prevention and control, and the associated risks of any contact with the deceased who is suspected of, or confirmed with, COVID-19, and of self-isolation protocols in line with current national guidelines on isolation.

13. Care after death includes:

- Respecting the spiritual, religious, and cultural wishes of the deceased and their key contacts, where possible, should be taken into consideration and ensuring legal obligations are met
- Ensuring timely verification of death
- Preparing the deceased for viewing, where appropriate, and supporting the key contacts
- Offering key contacts who are present the opportunity to participate in the process and supporting them to do so
- Facilitating people's wishes for organ and tissue donation where it is possible. Organ donation is only possible from intensive care units and emergency departments and can only be organised before the person dies in donation after circulatory death (DCD) or before the withdrawal of organ support in the case of donation after brain death (DBD). However whole-body donation to science and tissue donation is possible after death³⁸. Cornea donation can happen up to 24 hours after death and can take place in hospitals, hospices, and funeral homes³⁹.
- Ensuring, where relevant, that key contacts are informed about the need for post-mortem examination and given information about possible organ and tissue retention and disposal methods
- Preparing the deceased for transfer to the mortuary or the funeral director's premises
- Ensuring that the privacy, dignity, and respect of the deceased is maintained at all times
- Ensuring that the health and safety of everyone who comes into contact with the deceased is protected
- Returning the deceased's personal possessions to their key contacts
- Use of appropriate PPE in line with UK Health Security Agency guidance.
- Appropriate disposal of controlled drugs^{40,41,42}. This is of particular importance when the person dies in their own home.

Legal aspects

14. In this document, the term 'coroner' is used to represent the role of the coroner in England, Wales and Northern Ireland, and the procurator fiscal in Scotland. The shortened version is used only for brevity and ease of reading. It is essential to comply with legal requirements. See Appendix 2 for deaths that require an investigation by the coroner. It is useful to note that 40 per cent of all deaths in 2019 were reported to the coroner in England and Wales, a decrease of four per cent since 2018 and the lowest number since 1998⁴³. An estimated 11,000 deaths are reported to the Crown Office and Procurator Fiscal Service (COPFS) in Scotland every year⁴⁴ which, for 2019, equates to approximately 19 per cent of all deaths in Scotland⁴⁵. In Northern Ireland there were 15,758 deaths in 2019 of which 28 per cent were referred to the coroner's office⁴⁶.
15. All staff caring for the deceased need to ensure they are familiar with deaths that require such a referral, as this will facilitate the correct personal care and enable staff to prepare the key contacts both for a potential delay in the processing of the MCCD and the possibility of a post-mortem examination.
16. When there is a death of a person detained under the Mental Health Act or in custody, it must be reported to the coroner and will be subject to a coroner's inquest, or procurator's fiscal investigation if in Scotland. Such deaths will always be investigated by the coroner and police, and for those in custody by the Police Prisons Officer. A specialist forensic post-mortem examination is likely to be undertaken. Where the person was detained, or was liable to be detained, under the Mental Health Act at the time of death, the provider must notify the Care Quality Commission under Regulation 17 of the Health and Social Care Act 2008⁴⁷. The team responsible for the deceased's care usually completes forms. For all expected deaths in prisons, the Prison and Probation Ombudsman will investigate the death and the findings will be shared with the coroner prior to the inquest.
17. Guidance is available on the care of vulnerable adults⁴⁸. If a safeguarding issue becomes apparent after death, clearly documented concerns should be raised with social services, the police, and the coroner in line with local processes and guidance.
18. Where the person had an illness that requires referral to the coroner, (e.g. mesothelioma) but dying was anticipated, it is not necessary to involve the police. Referral to the coroner does not automatically require a post-mortem, but a post-mortem can be useful to assess the extent of the disease or other factors contributing to death.
19. The deceased must have been seen by the doctor in person or by video in the previous

28 days prior to death or in person after death.⁴⁹ The consultant in charge of the care remains ultimately responsible for the deceased whilst under hospital/hospice care, and the general practitioner (GP) practice in primary care.

20. Where a doctor has not attended the deceased within 28 days of the death (including via video/visual consultation) OR seen them after death in person, the MCCD may still be completed, however, the death must be referred to the coroner⁵⁰.
21. From Spring 2023 it is possible that it will be statutory (in England and Wales) for all non-coronial deaths to be scrutinised through the medical examiner system. This will involve scrutiny of the medical notes by a medical examiner to agree the proposed cause of death through discussion with the certifying doctor, discussion of the cause of death with the key contact, and to establish if they have any concerns prior to the MCCD being released. In Scotland, the Certification of Death Act (2011) ensured a national review system for checks on MCCD accuracy⁵¹.
22. The certifying medical practitioner has overall responsibility for identifying and communicating the presence of any implanted devices or radioactive substances. They are also responsible for identifying the appropriate person to deactivate and remove implants, to liaise with the appropriate medical physics department regarding radioactive treatments and to advise mortuary staff and funeral directors. For information required by mortuary staff and funeral directors see Appendix 3.
23. The Coronavirus Act 2020, which introduced easements to death certification processes and cremation forms, expired at midnight on 24 March 2022. Some easements continue⁵⁵, e.g. The Cremation (England and Wales) Regulations 2008 has been amended and Cremation Form 5 is no longer required⁵². The completion of the Cremation Confirmatory Certificate (Form C) is no longer required for cremation in Northern Ireland, and modifications have been made to Cremation Form B 53. For Northern Ireland, the legislation to extend the death certification process under COVID has been extended until 24 Sept 2022. In Scotland, the Certificate of Registration of Death (Form 14) is required for both cremation and burial and is issued by the Register Office once the death has been registered with the MCCD (Form 11)⁵⁴. All four nations have updated their registration of death processes to support electronic/remote registration⁵⁵.

Care after death

Responsibility for care after death

24. If present at the actual time of death, the registered nurse, doctor, ambulance clinician or appropriately trained registered professional⁵⁶ needs to record the time, who was present, the nature of the death, and to record their own name and contact details in the nursing, medical or ambulance documentation. The official time of death is when the verification of the death takes place.
25. They will need to record details of any relevant devices such as pacemakers and intrathecal devices, or Fixion nails. If the deceased person has a cardiac defibrillator which has not yet been deactivated⁵⁷, local policy should be followed, and steps taken to ensure it is deactivated before the person is moved to the mortuary or funeral director. None of these devices prevent cremation but they will need to be removed prior to cremation by appropriately trained mortuary staff or funeral director⁵⁸.
26. If a carer is present with the person in the home / care home then they should be advised to call the GP practice (in hours) or 111 out of hours to ensure appropriate support and a plan to verify the death. If the ambulance service has been called and attended the deceased, they will have verified the death.
27. The person present needs to be aware of any pertinent details in the deceased's Advance Care Plan that relates to care after death, and to act on this, as usually these wishes are time critical. Such examples are:
- Spiritual, religious, and cultural preferences especially related to urgent release for burial or cremation⁵⁹. Where available, advice from the spiritual care or chaplaincy department can be sought to support with the wishes of the deceased and their key contacts.
 - Wishes for repatriation: The local funeral director will advise and address the specific feasibilities⁶⁰.
 - Whole body donation: Medical schools are now looking to gradually resume donations services. However, there may be limitations for some time and donors should ensure they have alternative funeral plans.
 - Wishes for organ and tissue donation: Donations are still being accepted but not from those who are COVID-19 positive or suspected⁶¹.

Referral to the coroner

28. For deaths that require referral to the coroner, please see Appendix 2. If a person was found unexpectedly deceased in their own home by a carer, then the police should be called. They would then take custody of the deceased, and ensure the safety of the home. Please note

that COVID-19 is a notifiable disease but not reportable to the coroner; further information of notification of infectious diseases is also found in Appendix 2. The following details may be required when reporting a death to the coroner:

- The professional's telephone contact number
- The deceased's name, address, date of birth
- GP details
- Key contact name(s), contact details and relationship to the deceased
- Date and time of death
- Details of the person who verified death
- Details of what happened leading up to the death, including who was present at the death

29. If the case is being referred to the coroner because the cause of death is unknown or the death is unexpected, seek advice before moving or removing anything that might be relevant to establishing the cause of death. It is anticipated that mental health and prison services would have robust policies on unexpected death as all deaths would be referred to the coroner and would need police attendance at an undisturbed scene of death. If key contacts have any concerns about the death these should also be documented (and in this instance it is important to maintain the deceased body and environment and seek advice from the coroner).

Verification

30. When death occurs inform the medical practitioner primarily responsible for the person's care. In acute trusts it is helpful if verification occurs within one hour. In other settings it is helpful if it takes place within four hours. Verification of death needs to be completed by a doctor⁶², appropriately registered nurse⁶³ or ambulance clinician⁶⁴ before the deceased is transferred from the care setting.^{65 - 66} In Scotland it is recognised that any registered professional can undertake this act of care with appropriate training⁶⁷. It is important to note that due to Article 2 of the Human Rights Act 1988⁶⁸, and subsequent inquests, prisons are exempt from verification of death by registered nurses.

Issuing of the Medical Certificate of the Cause of Death (MCCD)

31. **Verification** of death is the process of **confirming the fact of death**. It is different from certification of the cause of death. **Certification** is the process of **issuing a MCCD**, and this is the responsibility of a medical practitioner⁶⁹. It is good practice to ensure that, when the death need not be referred to the coroner, the MCCD is ideally issued within one working day so burial or cremation arrangements are not unduly delayed. At the present time,

emailing of the MCCD to the Register Office is possible⁷⁰.

32. For hospitals in England and Wales where a medical examiner is appointed, there may be a delay of around half a day before the MCCD is issued⁷¹ due to review and scrutiny of the proposed cause of death to ensure overall accuracy of the MCCD^{72 73}.

Issuing of the Death Certificate (Certified copy of an entry of death)

33. The key contact notifies the registrar by telephone or email to begin the death registration process. The scope of individuals entitled to be the key contact has been extended to include funeral directors on behalf of the family, if necessary. The bereavement office notifies the registrar by email with a copy of the MCCD and contact for the bereaved key contact. The bereavement office informs the key contact that the respective registrar has been sent the MCCD and that they must book an appointment using the online or telephone booking system, to attend that registrar's office to register the death in person. An electronic copy of the certificate for burial or cremation (known as the Green form), can be shared with the funeral directors. The death certificate (certified copy of the entry of death) can be emailed to the key contact and a hard copy will be posted in due course^[i]. If there is no access to email or internet an alternative method should be explored. The police can be of assistance in locating key contacts and breaking significant news if the care organisation are unaware of who this is.

Communication – with key contacts

34. There are specific visiting guidelines for those who are dying in hospital, hospice and care home settings⁷⁴. It is essential that if the key contacts are not present at the time of death there is sensitive and honest communication with the key contact and that this has previously been agreed^{75 76}. Communication may have to occur via telephone or virtually. This is extremely difficult for both the key contact to receive bad news and the health or social care professional delivering it. The key contact must be prepared for this call if possible and great care should be taken to ensure information is conveyed in a sensitive manner. For the person dying at home with care, in line with national guidance⁷⁷, it is essential that the health care professional who receives the call from the carer informing them of the death offers emotional and practical support to the caller at this time, and the GP practice supports the key contact after death⁷⁸.
35. It is vital that when the death is expected, those with additional needs, e.g. interpreter or assistance to answer the phone, are thought about and strategies put in place for the call. Specific guidance has been developed by Health Education England (HEE) to help clinicians break bad news by phone⁷⁹. Additional resources for bereaved people with learning difficulties have been developed by Beyond Words⁸⁰. If children are involved, adults may require guidance

on how best to convey the news to children⁸¹.

36. After the death has been verified, always provide the key contact with information on the processes to be followed after a death. In hospital this would usually be to call the bereavement office so that details regarding whether the death is to be referred to the coroner, or what is to be written on the Medical Certificate of the Cause of Death, can be discussed. Where a hospital does not have a bereavement office, and in hospices and care homes, the key contact will be instructed to call the ward or care home manager, respectively. In the community, including where the person has died in their own home, the key contact would be instructed to call the GP on the next working day. The bereavement office, ward manager, hospice, care home or GP surgery will be aware of bereavement agencies available to support key contacts in their local area and provide help in a supportive way. The MCCD is emailed directly to the Register Office.

Communication – with professionals

37. It is vital that processes are in place to protect confidentiality, and these continue after death. However, this does not prevent the use of sensible rules to safeguard the health and safety of all those who may care for the deceased⁸².

38. There needs to be clear communication regarding any infection risk and the presence of implantable devices to mortuary staff and funeral directors. If the deceased had a notifiable infection there is detailed guidance available, including on infections requiring the use of a body bag⁸³, and whilst it is not mandated for those who died of COVID-19, it is recommended in many circumstances⁸⁴. All those who previously cared for the deceased need to be notified of the death.

Responsibility for personal care after death

39. In NHS hospitals, hospices, and private nursing homes the personal care after death is the responsibility of a registered nurse, although this, and the packing of the deceased's property, may be delegated to a suitably trained healthcare support worker wearing appropriate PPE. The registered nurse is responsible for selecting and wearing PPE⁸⁵ correctly, identifying the deceased, being aware of when to refer to the coroner and communicating accurately with the mortuary or funeral director (in line with local policy).⁸⁶

40. In care homes without a registered nurse, the home manager is responsible for ensuring that professional carers are trained appropriately and that they have the relevant competence and PPE for the role. In prisons, personal care after death is the responsibility of the prison service (not prison healthcare), and all property is left for the family liaison officer to return to the key contact.

41. It is essential to update and organise the medical and nursing records⁸⁷ as quickly as possible so they are available to the bereavement team and other interested professionals, such as the medical examiner and pathologists.

Time requirements and viewing

42. The personal care after death needs to be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing the deceased need to be completed as soon as possible within this time. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four to six hours of death is optimum⁸⁸.

43. Prior to COVID-19 all key contacts were usually offered the opportunity to view the deceased, and there is evidence that, even in traumatic circumstances, key contacts found this helpful⁸⁹. Viewing may still not be permitted in acute hospitals in order to reduce infection risk, and later mortuary viewing may also not be possible depending on local arrangements⁹⁰. However, it should be noted that viewing is permitted when overseen by those who are experienced in the care of the deceased⁹¹ and some hospices are able to facilitate viewings.

44. The key contact will be required to follow Infection Prevention and Control guidelines and the use of PPE. It is also possible for supported remote bereavement visits using visual digital technology⁹². Some hospitals have bereavement services that are familiar with the care needed to undertake this, e.g. Northern Care Alliance, and can be contacted for further information.

45. Key contacts should be guided on how to support children and young people who are also bereaved and specific information on viewing a body with a child. ⁹³⁹⁴

Environment

46. The deceased needs to be cared for with dignity. In the past it had been suggested that in hospitals such factors helping to contribute to this were a single room that had a feeling of homeliness, informal gathering spaces where key contacts can meet and confer, guest rooms for key contacts to stay and appropriate areas for viewing⁹⁵. Now, with visiting restricted in the dying period, and viewing of the deceased not generally permitted, it is helpful if the surrounding environment still conveys this respect, e.g. the room is tidy and organised as it would be if key contacts were present. It is important that the deceased's spiritual, religious and cultural wishes are attended to⁹⁶ and that the attitudes and behaviour of staff

are respectful and reassuring of the care provided to the deceased; both to bereaved carers by phone (even if they are not physically present), and also to other members of staff, e.g. porters.

47. If the deceased dies an expected death in their own home, then those present – either families or care agency staff - need to ensure the dignity of the deceased is maintained. If the person dies outside of their bed / sofa space, they can, with assistance, be returned safely to the bed / sofa and their bodies covered until the death can be verified.
48. Residents in communal settings, such as care homes and prisons, have often built significant relationships with other residents and members of staff and they will need to be informed of the death. Compassionately consider how to address their need to know of the death within the boundaries of confidentiality. If the person has died in an environment where other people may be distressed by the death then inform them sensitively, using relevant resources as appropriate, (e.g. those produced to assist those with learning disabilities⁹⁷), that the person has died. Be careful not to provide information about the cause and reason for death. Consider signposting to bereavement support in these settings.

Mementoes

49. Mementoes or keepsakes, (for example, locks of hair, handprints, etc.) may be offered and taken at the time of care after death. Standard Infection Control Precautions (SICPs) should be adhered to. ⁹⁸ Funeral Directors can also provide this service.

Packing property

50. Using standard infection control precautions, pack personal property, showing consideration for the feelings of those receiving it and in line with local policy. Valuables should be placed in a valuables property envelope.
51. Clothes that are contaminated or soiled should ideally, with key contact consent, be disposed of but can be packed into property bags and stored in a clean area to return to the key contact if desired. The key contact collecting the property must be advised to wash hands carefully after handling any possessions initially. Place all clothing directly into a washing machine with a detergent wash (either bio or non-bio), at 60 degrees centigrade. Wipe down any hard items with warm soapy water and leave to dry or, if they are dishwasher safe, place in the dishwasher.
52. Record all aspects of care after death in locally relevant documentation and identify the professionals involved.

Disposal of controlled medicines

53. It is expected that organisations, e.g. hospitals, hospice, care homes, have the appropriate

procedures to safely dispose of controlled medicines. In the home setting family and key contacts should be advised to call the local pharmacy to arrange the return and safe disposal of controlled medicines. If there is no family or key contact, then the district nursing team or palliative care team should arrange for the collection and safe disposal at a local pharmacy in line with national guidance.

Transfer of the deceased from the place of death to the mortuary or funeral director.

54. The privacy and dignity of the deceased on transfer from the place of death is paramount. Each organisation involved is responsible for ensuring that the procedures adopted to transfer bodies, including those who are bariatric, respect the values of personal dignity, and these are incorporated in the design of the concealment trolley and the way the deceased is covered. The deceased may be transferred in a bed with an appropriate cover or concealment trolley. It is not recommended to transfer the deceased in ways that might make them appear as alive to others, e.g. with an oxygen mask in situ. In community settings a funeral director will usually undertake transfer, although on rare occasions the deceased's executor (generally a key contact) may also do this.

Cleaning the space

55. The process of environmental decontamination/cleaning should happen soon after the deceased is moved from the area. Special attention should be paid to frequently touched surfaces, e.g. medical equipment⁹⁹, door/toilet handles and locker tops, call bells, over bed tables and bed rails. They should be decontaminated as per IPC guidance¹⁰⁰.

Acknowledgement of the emotional impact

56. It is important to address any staff anxieties or concerns as a result of managing the deceased. It may be that staff involved in delivering bad news, managing property, and caring for the deceased require additional opportunities, such as a debrief, to explore emerging feelings in a safe, structured manner. Attention to, and being sensitive about, the individual's needs demonstrates a caring approach and can be instrumental in averting any future crises¹⁰¹.

Personal care after death

Personal Protective Equipment (PPE)

57. To maintain the safety of those carrying out the personal care after death, these guidelines should be used in conjunction with the local Infection Prevention and Control policy and applied to all adult deaths irrespective of any COVID-19 status (i.e. not

suspected, suspected, confirmed)¹⁰². Please note, local guidance should be referred to regarding the requirement of high-level or low-level PPE.

Equipment to be considered

58. It is essential to be well prepared before carrying out the personal care of the deceased. Thoughtful consideration should be given for the equipment needed to undertake the procedure with respect and dignity for the person, ensuring all equipment is gathered prior to undertaking the personal care of the deceased.

- Personal Protective Equipment
- Clean bed sheets
- Shroud or clean clothing for the deceased
- Soap and towels (or equivalent)
- Mouthcare equipment
- Mouth covering (cloth or face mask)
- Brush or Comb
- Contenance Pads
- Dressings
- Tape
- Name bands
- Mortuary label (or equivalent)
- Valuables envelopes and sealing plastic bags

Deaths requiring coroner involvement

59. Where the death has been referred to the coroner, there will be some parts of the personal care after death that cannot be carried out, and this will depend on the reason for referral.

60. **Forensic investigation referral:** When the death is being referred to the coroner as the circumstances surrounding the death give rise to suspicion, there should be minimal contact with the body. Leave all drains, tubes, intravenous (IV) cannulae and lines in situ and IV infusions clamped but intact (this includes syringes with controlled drugs from syringe pumps). Leave any urinary catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case this destroys evidence. Continue using universal infection control measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death. Ensure the cardiac defibrillator is deactivated.

61. **Cause of death referral:** When the death is being referred to the coroner to investigate

the cause of death, but where there are no suspicious circumstances, then leave IV cannulae and lines in situ and catheters spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy. Leave the ET tube in situ as cutting the tube deflates the balloon holding the tube in position. The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through post-mortem examination. Personal care can then be given as for deaths without coroner involvement. Ensure the cardiac defibrillator is deactivated.

Deaths without coroner involvement

- 62. Particularly in the home setting, some key contacts/carers may wish to assist with the personal care. Prepare them sensitively for changes to the body after death and be aware of manual handling and infection control issues. Ensure the cardiac defibrillator is deactivated.
- 63. Carry out all personal care of the deceased after death in accordance with safe manual handling guidance. It is best practice to do this with two people, one of whom needs to be a registered nurse, nursing associate, or a suitably trained person.

Procedure: personal care after death

- 64. It is important to note that during this procedure, consideration must always be given to any care related to the deceased’s spiritual, religious, and cultural needs.
- 65. Where COVID-19 is either suspected or confirmed, special care must be taken in relation to moving the deceased or removing any aerosol generating equipment from the deceased*.

ACTION	RATIONALE
Adopt standard infection control precautions. Perform hand hygiene prior to donning selected PPE (see Appendix 4).	To ensure protection of the person carrying out the personal care from cross-contamination.
Lay the deceased on their back, adhering to manual handling policy; straighten their limbs, (if possible) with their arms lying by their sides.	To maintain the deceased’s dignity, ensure the deceased is lying straight prior to rigor mortis which occurs 2-6 hours after death.

ACTION	RATIONALE
<p>Ensure the person is appropriately covered with a clean sheet.</p> <p>If it is not possible to lay the deceased flat due to a medical condition, or rigor mortis, then seek guidance from the mortuary staff or funeral director.</p> <p>The mortuary staff and porters, or funeral directors (depending on place of death), should be alerted if the deceased is bariatric.</p>	<p>To maintain the deceased's privacy and dignity.</p> <p>Alternative transportation may be required.</p> <p>To ensure they have the appropriate equipment to transfer the deceased.</p>
<p>Leave one pillow under the head.</p>	<p>Supports alignment and helps the mouth stay closed.</p>
<p>Close the eyes by applying light pressure for 30 seconds. This also applies when the deceased is donating their corneas.</p> <p>If the eyelids fail to close, then explain sensitively to the key contact/carers that the funeral director will resolve the issue.</p> <p>Do not apply tape over the eyelids.</p>	<p>To maintain their dignity, and for tissue protection in case of corneal donation</p> <p>Tape can mark the skin.</p>
<p>Tidy the hair as soon as possible after death and arrange into the preferred style, (if known).</p> <p>A lock of hair as a memento may be offered. Place in a plastic bag and seal.</p>	<p>To guide the funeral director for final presentation.</p>
<p>Clean the mouth to remove debris and secretions. * <i>Caution where COVID-19 is suspected or confirmed.</i></p> <p>Clean and replace dentures as soon as possible after death.</p> <p>If they cannot be replaced send them with the deceased in a clearly identified receptacle.</p>	<p>For hygienic reasons.</p> <p>To retain the facial shape of the deceased.</p> <p>The funeral director will likely be able to secure in place.</p>
<p>Where the jaw may need additional support, place a small pillow or rolled up towel under the chin.</p> <p>Do not bind the jaw with bandages. Some people have jaws that will never close; notify the mortuary staff or funeral director if this is the case.</p>	<p>To close the mouth maintaining the facial shape for the deceased's dignity.</p> <p>This will leave pressure marks on the face.</p>
<p>Do not shave the deceased person. Usually the funeral director will do this.</p> <p>Be aware that some faith groups prohibit shaving.</p>	<p>Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later.</p>

ACTION	RATIONALE
<p>Drain the bladder by gently pressing on the lower abdomen for 30 seconds and collecting the urine in a receiver, or catheter bag where a urinary catheter is in situ.</p>	<p>The body can continue to excrete fluids after death.</p>
<p>Remove catheter bag and spigot any urinary catheters, (if still in situ).</p> <p>Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum. Do not pack.</p>	<p>To prevent fluid leakage.</p>
<p>Clamp any drains, and intravenous or subcutaneous lines still in situ. Remove any connected infusion lines and infusions.</p>	<p>To prevent leakage.</p>
<p>Contain leakages from the oral cavity or tracheostomy sites by suctioning and positioning. Suction and spigot nasogastric tubes. * <i>Caution where COVID-19 is suspected or confirmed as this is an aerosol generating procedure and appropriate PPE should be worn.</i></p> <p>Cover exuding wounds or unhealed surgical incisions with a clean, absorbent dressing and secure with an occlusive dressing.</p> <p>Leave stitches and clips intact. Cover stomas with a clean bag.</p> <p>If the body is leaking profusely then take time, pre-transfer to the mortuary or funeral home, to address the problem.</p> <p>Ensure mortuary staff and funeral directors are informed of any potential for profuse leakage.</p>	<p>Avoid strongly adhesive tape on any occlusive dressing as this can be difficult to remove at the funeral directors and can leave a permanent mark.</p> <p>To enable appropriate positioning of the deceased in the refrigeration areas.</p>
<p>Wash the deceased, unless requested not to do so for spiritual/religious/cultural reasons, or the death is being referred to the coroner.</p> <p>Key contacts and/or carers may wish to assist with washing, and they may have been caring for the person prior to death. They must be aware of the risks of potential COVID-19 infection and, depending on the place of death, wear PPE as instructed.</p>	<p>For hygienic and aesthetic reasons. Respecting the spiritual, religious, and cultural preferences of the deceased.</p>

ACTION	RATIONALE
<p>When moving the deceased air can be released; this should not be mistaken for breathing.</p> <p><i>*Caution where COVID-19 is suspected or confirmed, place cloth or face-mask over the mouth of the deceased when moving them.</i></p> <p>Further soiling may also occur.</p>	<p>Sensitively share this information with the key contact or carer assisting with the personal care.</p> <p>To prevent the release of droplets from the respiratory tract during movement.</p>
<p>Dress the deceased appropriately before they go to the mortuary or funeral directors. This may be in a shroud or personal clothing depending on the place of death, local policy or wishes of the key contacts.</p> <p>Key contacts and/or carers may want to dress the deceased. As above, when moving the deceased, air can be released; this should not be mistaken for breathing.</p> <p><i>*Caution where COVID-19 is suspected or confirmed, place cloth or face-mask over the mouth of the deceased when moving them.</i></p> <p>Further soiling may also occur.</p> <p>The deceased should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary on site. The Funeral Director may ask for a second set of clothes for the deceased to be buried/cremated in.</p>	<p>To ensure the deceased's dignity is always preserved</p> <p>Sensitively share this information with the key contact or carer dressing the deceased.</p> <p>To prevent the release of droplets from the respiratory tract during movement.</p> <p>To maintain their dignity and privacy.</p>
<p>Remove jewellery in the presence of another member of staff, unless specifically requested by the key contact to do otherwise, and document this according to local policy.</p> <p>Any jewellery removed must be placed in a valuable's property envelope, and sealed in a clear plastic bag. Provide a signature if any jewellery is removed.</p> <p>Secure any rings left on with minimal tape, documented according to local policy.</p> <p>Be aware of spiritual/religious/cultural ornaments that need to remain with the</p>	<p>To meet legal requirements and key contact's wishes.</p> <p>Safekeeping of valuables.</p> <p>To reduce the risk of the ring(s) falling off.</p>

ACTION	RATIONALE
deceased. Ensure these are clearly documented.	To respect the wishes of the deceased /key contact. Refer to their Advance Care Plan if in place.
<p>Clearly identify the deceased with a name band on their wrist or ankle.</p> <p>As a minimum this needs to identify their name, date of birth, address, (and ward if a hospital in-patient) and ideally their NHS number.</p> <p>In the community setting, it is recognised that identification of the deceased is likely to be via a verification of death form.</p> <p>Do not use a toe tag.</p>	To ensure correct identification of the deceased.
<p>With a clean sheet placed under the deceased, wrap the body ensuring face and feet are covered and all limbs are held securely in place. In community settings, the funeral director will do this.</p> <p><i>*Caution where COVID-19 is suspected or confirmed, place cloth or face-mask over the mouth of the deceased when moving them.</i></p> <p>Use tape to secure the sheet in place.</p> <p>Do not bind the sheet or tape too tightly.</p>	<p>To protect the condition of the deceased and avoid damage during transfer of the deceased.</p> <p>To prevent the release of droplets from the respiratory tract during movement or transfer.</p> <p>This can cause abrasions and/or disfigurement.</p>
Complete documentation such as the 'notification of death' card and attach to the outside of the sheet of the deceased.	To ensure correct identification of the deceased.
<p>If there is significant leakage, place the deceased into a body bag.</p> <p>A body bag may also be required for some infectious notifiable diseases.</p> <p>A body bag is not routinely required for COVID-19.</p>	To prevent risk of contamination to those handling the body from leakage of fluids.
If the body continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director.	To prevent risk of contamination to those handling the body from increased leakage of fluids.
<p>Request transfer of the deceased:</p> <p>In hospital settings it is best practice for porters to take the deceased to the mortuary within one hour of request, to be refrigerated within four hours of death.</p>	Prevents distress to surrounding patients, and (if requested) ensures tissue donation can take place.

ACTION	RATIONALE
<p>In community settings such as community hospitals, care homes and hospices, local arrangements should be made with the funeral director for collection of the deceased, ideally within 4 hours of death.</p> <p>In the deceased's own home, local arrangements can be made by the key contacts. Support, guidance, and signposting with this may be needed depending on the circumstances.</p>	<p>Optimum time for refrigeration of the deceased is 4-6 hours.</p> <p>To ensure arrangements are in place for the transfer of the deceased to the funeral director or equivalent.</p>
<p>Using PPE, pack the property of the deceased as per local policy and in line with infection prevention and control.</p> <p>Any hard valuables, such as bank cards and mobile phones, must be wiped down with disinfectant wipes, allowed to dry, placed in a Valuables property envelope, and sealed in a clear plastic bag. Provide a signature for any valuables.</p> <p>Ensure all property is packed with care and labelled with the deceased's details. In the clinical setting, list all property in the property book (or equivalent).</p>	<p>To reduce the risk of infection from contamination of the hard valuables.</p> <p>Ensures a record of all property is available when handing over to the key contacts.</p>
<p>Clean the area as soon as possible after the deceased has been transferred.</p> <p>Used linen need to be disposed of in line with standard infection control precautions.</p> <p>Ensure contaminated gloves are disposed of and clean gloves are donned to carry out cleaning of the room. Perform hand hygiene between glove changes.</p> <p>In the clinical setting, follow local infection control policy for cleaning the area. Pay special attention to frequently touched surfaces such as door handles, bed frames, table tops etc. Follow local IPC policy for decontamination.</p> <p>In the home of the deceased, advise the key contact of cleaning needs according to the Standard Infection Control Precautions.</p> <p>Where a hospital bed or any other loaned equipment is in the home, follow local policy on advice for</p>	<p>To eliminate potential spread of infection</p> <p>To eliminate cross-infection from contaminated gloves.</p>

ACTION	RATIONALE
decontamination and return of the equipment.	
Remove PPE in the correct order (see Appendix 4) and dispose of as per local policy. Perform hand hygiene.	To eliminate cross-contamination.
Document in the clinical notes that personal care after death has been carried out, and the property, including any valuables, has been listed, and the conversation with and advice given to the key contact(s) of the deceased.	To ensure a clear record of events is recorded.
Give opportunity for staff debrief. Be sensitive to own and others experience of caring for the deceased prior to dying and/or at the time of death. Further support or reflection may be needed.	Allows for anxieties and concerns to be addressed at the time, giving recognition and validity to the feelings, and may avert potential of unexplored emotions reaching crisis point.

Education and Training

Pre-registration training

66. We recognise that since the previous edition of care after death¹⁰³ education and training on all aspects of care after death are increasingly included on all relevant pre-registration training curriculum – particularly for medicine, nursing, and social care. Health and social care workers at every level should be able to access pre-registration training around the care and responsibilities in relation to a death, including spiritual, religious and cultural awareness, bereavement training and concepts of self-care¹⁰⁴. It is expected that mortuary staff will be working towards or have completed the training by the Royal Society for Public Health (RSPH) - Level 3 Diploma in Healthcare Science (Anatomical Pathology Technology).

Induction and continued professional development

67. Commissioners should ensure that all staff, regardless of sector or employer, have access to appropriate training. The pertinent aspects of care after death for the relevant staff are:

STAFF GROUP	CARE AFTER DEATH TRAINING
<i>All staff</i>	Consider bereavement awareness training.

<p><i>Medical Practitioners</i></p>	<p>Communication about breaking bad news and managing important conversations, including through remote/virtual/telephone communications; verification of death; completion of MCCDs; appropriate referrals to the coroner and the new Medical Examiner system (England & Wales) / Death Certification Review Service (Scotland).</p> <p><i>It is noted that Organ and Tissue donation after death is governed by different laws in different UK countries and training must be country specific and cover the different consent provisions with regard to post-mortem examination and possible organ and tissue retention and organ and tissue donation</i></p>
<p><i>Nursing Staff</i></p>	<p>Communication about breaking bad news and managing important conversations, including through remote/virtual/telephone communications; verification of expected adult death; personal care after death including managing the deceased's property; coronial referrals and effect on viewing, documentation of care after death, safe disposal of controlled medicines and the new Medical Examiner system / Death Certification Review Service (Scotland).</p>
<p><i>Ambulance Clinicians</i></p>	<p>Accessing electronic patient records that record people's wishes and preferences; communication about breaking bad news and managing important conversations; recognition of life extinct and supporting those present at the time of death; appropriate referrals to the coroner and documentation of care.</p>
<p><i>Porter Staff</i></p>	<p>Safe handling and transferring of the deceased while maintaining their dignity and respect; sensitive communication with those present at the bedside.</p>
<p><i>Care agency staff - Social Care, NHS or privately funded</i></p>	<p>Training on personal care after death; communication and responsibilities if the deceased has no family or key contact;</p>

	sensitive communication with the bereaved and documentation of care
<i>Domestic Staff</i>	Awareness training on the needs of the bereaved.
<i>Bereavement Support/Liaison Staff</i>	Sensitive communication with the bereaved and bereavement support offered to key contacts; process for collection of MCCDs; referral to the coroner and the Medical Examiner system / Death Certification Review Service (Scotland).
<i>APT Mortuary staff</i>	Management of the deceased; supporting viewings; communication with families, and systemic working with others in the care setting and the new Medical Examiner system.

Individual and team debrief

68. The opportunity for debriefing should be available for staff after a death¹⁰⁵. In places of care where deaths happen frequently, e.g. acute hospital trusts, debriefing may take place after exceptionally challenging deaths or when the cumulative effect of many deaths is recognised. Some Trusts offer After Action Reviews (AAR)¹⁰⁶ with a facilitator to support this reflective learning in practice. Schwartz rounds are also routinely organised in many organisations to offer further space for collaborative reflection and support¹⁰⁷. This can now be offered via a fully on-line, slightly smaller group-based Schwartz type round called Team Time¹⁰⁸. Mortality and Morbidity meetings are another resource to support reflection and potential improvement in care especially when facilitated by a standardised mortality review process.

Organisational learning

69. All incidents related to care after death should be accounted for within the organisation for local action and governance with escalation, according to the seriousness and widespread applicability of any learning points or actions. Serious incidents and near miss incidents that take place in a mortuary setting must be reported to the Human Tissue Authority (HTA)¹⁰⁹. NB: HTA does not have jurisdiction in Scotland. All staff working in the mortuary should be aware of the reporting requirements and this should be addressed in training.

70. NHS Trusts are now required to participate in 'Learning from Deaths' with the purpose of extrapolating the learning and disseminating this information across the trust¹¹⁰. In a community setting it is also considered good practice to adopt a multi-disciplinary approach to learning from deaths¹¹¹.

71. Compliments and positive correspondence from key contacts are also used to support learning and improvements in providing quality care Trust wide. They are also a great source for providing a morale boost within the workforce.

Further learning resources

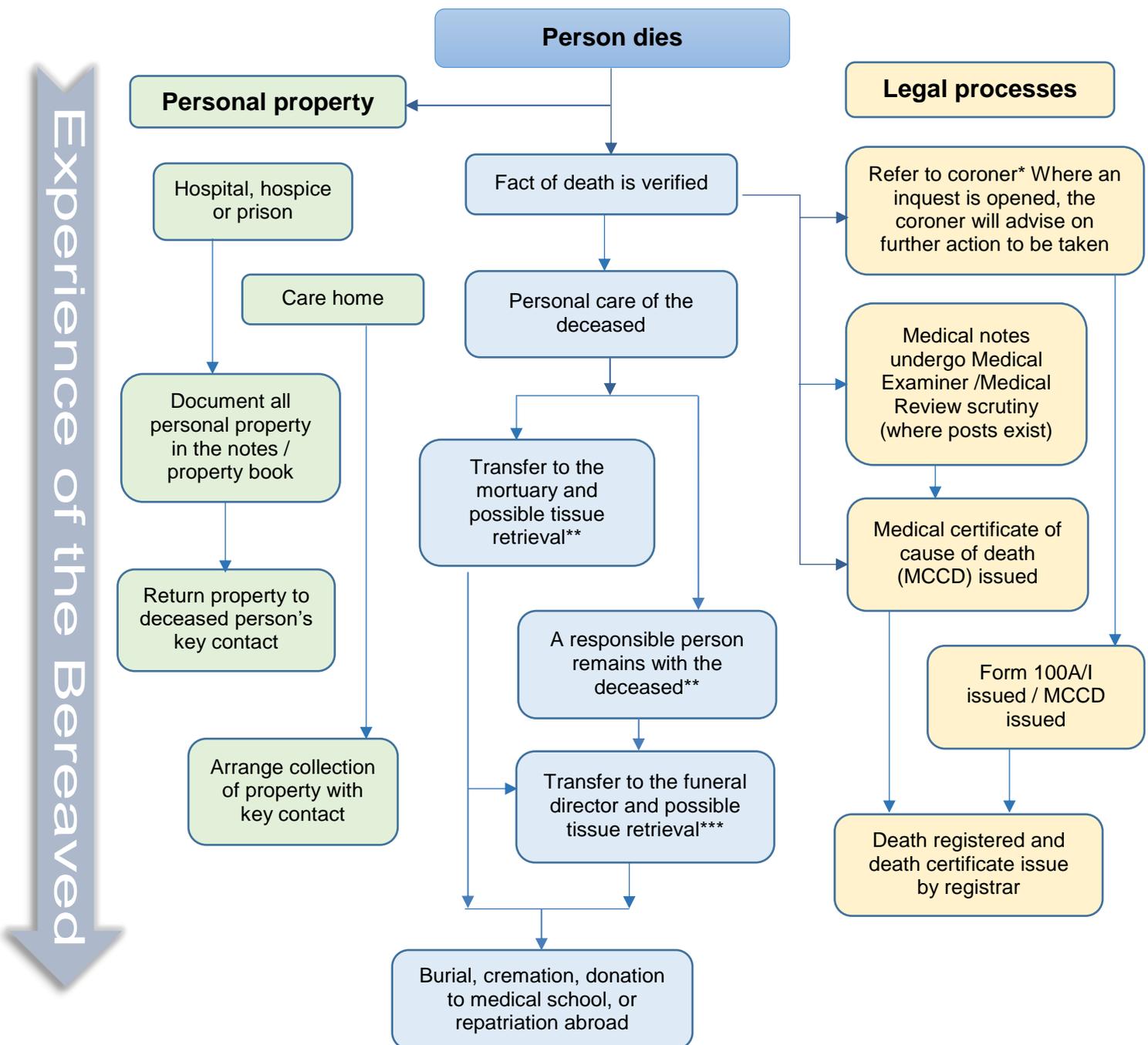
- Bereavement Advice Centre. What to do when someone dies: step by step checklist. [Information for professionals][Internet] Available from: <https://www.bereavementadvice.org/topics/what-to-do-when-someone-dies/step-by-step-checklist/>
- Health Education England. Learning hub. [Internet] Available from: <https://learninghub.nhs.uk> (Registration for access required)
- Marie Curie. Providing care after death. [Internet] 2022. Available from: <https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/final-days/care-after-death>
- NHS Education for Scotland. Support around death. [Internet] Available from: <http://www.sad.scot.nhs.uk/>
- Mental Health at Work Our Frontline. (Available from: <https://www.mentalhealthatwork.org.uk/ourfrontline/> (24/7 emotional support, by call or text with trained volunteers, or online resources, to workers who have been on the frontline throughout the COVID-19 pandemic.)
- NHS England. Professional Nurse Advocate. [Internet] Available from: <https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate/>
- Royal College of Nursing. Having courageous conversations by telephone or video during the COVID-19 pandemic. [Internet] 2020. Available from: <https://www.rcn.org.uk/professional-development/publications/rcn-courageous-conversations-covid-19-uk-pub-009-236>
- Royal College of Nursing. End of life care. [Internet] Available from: <https://www.rcn.org.uk/clinical-topics/end-of-life-care>
- Royal College of Nursing. End of life care and wellbeing for the nursing and midwifery workforce. [Internet] Available from: <https://www.rcn.org.uk/professional-development/professional-services/end-of-life-care-and-wellbeing-for-the-nursing-and-midwifery-workforce>

- Skills for Care. – End of life care [Internet] Available from:
<https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/end-of-life-care/End-of-life-care.aspx>

All links checked 21 June 2022

Appendix 1

Processes of care for the deceased



This whole process should be set within the context of the deceased's spiritual, religious, and cultural wishes about care arrangements. Family members and carers should be given information and support.

* See Appendix 2 for further information on deaths requiring coroner investigation

** This may be a health or care provider where no other responsible person is available e.g. NOK

*** Tissue donation is not possible where COVID-19 is suspected or confirmed

Appendix 2

Deaths requiring coroner investigation

Deaths requiring referral to the coroner in England, Northern Ireland or Wales, and the procurator fiscal in Scotland, for investigation are where the cause of death is unknown, sudden, suspicious, or unexplained; when the death:^{112 113 114}

- may be caused by violence, trauma, or physical injury, whether intentional or otherwise
- may be caused by poisoning, drug related, including adverse drug reactions (reportable under the Medicines and Healthcare Products Regulatory Agency – MHRA)
- may be the result of misadventure, intentional self-harm, or possible suicide
- may be the result of neglect, including self-neglect, or failure of care
- may be related to a medical procedure or treatment, a failure of a piece of equipment, an operation or before recovering from the effects of an anaesthetic
- may be due to an injury, disease, or industrial poisoning in the course of employment
- occurred where the deceased was not treated by a doctor during their last illness, or a doctor did not see or treat them for the condition from which they died
- occurred while the deceased was in custody or state detention, whatever the cause.

A person who dies from a notifiable infectious disease, e.g. COVID-19, is not a reason on its own to refer the death to the coroner.¹¹⁵

Notification of infectious diseases

Notifiable diseases are nationally reported in order to detect possible outbreaks of disease and epidemics as rapidly as possible, and it is important to note:¹¹⁶

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infectious disease, and without waiting for laboratory confirmation, at time of diagnosis.
- Registered medical practitioners in England are required to report COVID-19 positive deaths to NHS England. In Scotland, deaths are reported to Public Health Scotland, and in Wales to Public Health Wales. For Northern Ireland, they are reported to the Public Health Agency of the Northern Ireland Health and Social Care.
- All laboratories where diagnostic testing is carried out must notify their national Public Health authority of any confirmation of a notifiable infectious disease.

Appendix 3

Information required by mortuary staff and funeral directors

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

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

Appendix 4 Guide to donning and doffing PPE¹⁷



Public Health
England

This guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), Public Health Scotland, Public Health England, and NHS England as official guidance.

Guide to donning and doffing standard Personal Protective Equipment (PPE)

for health and social care settings

Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

- 1** Put on your plastic apron, making sure it is tied securely at the back.

- 2** Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

- 3** Put on your eye protection if there is a risk of splashing.

- 4** Put on non-sterile nitrile gloves.

- 5** You are now ready to enter the patient area.


Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

- 1** Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.

- 2** Perform hand hygiene using alcohol hand gel or rub, or soap and water.

- 3** Snap or unfasten apron ties the neck and allow to fall forward.


Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

- 4** Once outside the patient room. Remove eye protection.

- 5** Perform hand hygiene using alcohol hand gel or rub, or soap and water.

- 6** Remove surgical mask.

- 7** Now wash your hands with soap and water.


Please refer to the PHE standard PPE video in the COVID-19 guidance collection:

www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

If you require the PPE for aerosol generating procedures (AGPs) please visit:

www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

References (links all checked June 21 2022)

- ¹ The Schwartz Center for Compassionate Healthcare. Schwartz Rounds and membership. [Internet] 2022. Available from: <https://www.theschwartzcenter.org/programs/schwartz-rounds>
- ² Wren B-A. True tales of organisational life: using psychology to create new spaces and have new conversations at work. Abingdon: Routledge; 2016
- ³ Resuscitation Council UK. 2021 resuscitation guidelines. [Internet] 2021. Available from: <https://www.resus.org.uk/library/2021-resuscitation-guidelines>
- ⁴ Resuscitation Council UK . Resuscitation Council UK’s statement on fitness to practise. [Internet] 2017. Available from: <https://www.resus.org.uk/about-us/news-and-events/resuscitation-council-uks-statement-fitness-practise>
- ⁵ Resuscitation Council UK. Statements and resources on COVID-19 (Coronavirus), CPR and resuscitation. [Internet] Available from: <https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/> See also: Resuscitation Council UK. Statement: Updates to RCUK COVID-19 guidance in April 2022. [Internet] 2022. Available from: <https://www.resus.org.uk/about-us/news-and-events/statement-updates-rcuk-covid-19-guidance-april-2022>
- ⁶ Chambers L. Caring for your child at end of life: a guide for parents and carers. Bristol: Together for Short Lives; 2019. Available from: <https://www.togetherforshortlives.org.uk/wp-content/uploads/2019/11/TfSL-Caring-for-a-child-at-end-of-life-Parents.pdf>
- ⁷ Chambers L. Caring for a child at end of life: a guide for professionals on the care of children and young people before death, at the time of death and after death. Bristol: Together for Short Lives; 2019. Available from: <https://www.togetherforshortlives.org.uk/wp-content/uploads/2019/11/TfSL-Caring-for-a-child-at-end-of-life-Professionals.pdf>
- ⁸ Sands (Stillbirth and Neonatal Death Charity). Pregnancy loss and the death of a baby: guidelines for professionals. 4th ed. London: Sands; 2016
- ⁹ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID -19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>
- ¹⁰ NHS Education for Scotland. Guidance and supporting resources for practitioners undertaking the Confirmation of Death procedure in Scotland. Edinburgh: NHS Education for Scotland; 2020. Available from: <https://learn.nes.nhs.scot/28679/coronavirus-covid-19/death-and-bereavement/guidance-and-supporting-resources-for-practitioners-undertaking-the-confirmation-of-death-procedure>
- ¹¹ NHS England and NHS Improvement. Living with COVID-19: Visiting healthcare inpatient settings principles. [Version 5 updated 07 June 2022] [Internet] 2022. Available from: <https://www.england.nhs.uk/coronavirus/documents/c1606-living-with-covid-19-visiting-healthcare-inpatient-settings-principles/>
- ¹² Association for Palliative Medicine of Great Britain and Ireland. COVID-19 and palliative, end of life and bereavement care in secondary care: role of the specialty and guidance to aid care. [Internet] 2020 [Version 4, 20 April 2020] Available from: <https://apmonline.org/>
- ¹³ NHS England and NHS Improvement. Living with COVID-19: Visiting healthcare inpatient settings principles. [Version 5, updated 07 June 2022] [Internet] 2022. Available from: <https://www.england.nhs.uk/coronavirus/documents/c1606-living-with-covid-19-visiting-healthcare-inpatient-settings-principles/>
- ¹⁴ Mencap. Dealing with a bereavement. [Internet] Available from: <https://www.mencap.org.uk/advice-and-support/dealing-bereavement>
- ¹⁵ Hospice UK. Care after death: guidance for staff responsible for care after death. 3rd ed. London: Hospice UK; 2020. To request a copy, please contact clinical@hospiceuk.org
- ¹⁶ Hospice UK. 5th edition of care after death: registered nurse verification of expected adult death (RNVoEAD) guidance. 5th ed. London: Hospice UK; 2022. To request a copy, please contact clinical@hospiceuk.org
- ¹⁷ Academy of Medical Royal Colleges. A code of practice for the diagnosis and confirmation of death. London: Academy of Medical Royal Colleges; 2008. Available at: <https://www.aomrc.org.uk/reports-guidance/ukdec-reports-and-guidance/code-practice-diagnosis-confirmation-death/>
- ¹⁸ The Home Office. Reforming the coroner and death certification service: a position paper (Cm 6159). London: The Stationery Office; 2004 Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251078/6159.pdf

- ¹⁹ National Medical Examiner. Implementing the medical examiner system: national medical examiner's good practice guidelines. NHS England and NHS Improvement; 2020. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/08/National_Medical_Examiner_-_good_practice_guidelines.pdf
- ²⁰ Healthcare Improvement Scotland. Information on the Death Certification Review Service. [Internet] Available from: http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information.aspx
- ²¹ Leadership Alliance for the Care of Dying People. One chance to get it right: improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People; 2014. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf
- ²² NHS Blood and Transplant. Organ donation law in England. [Internet] Available from: <https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/>
- ²³ Gov.co.uk National Infection Prevention and Control . [Updated 09 June 2022] [Internet] Available from: <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/>
- ²⁴ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID -19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>
- ²⁵ National Pharmacy Association. COVID-19: guidance on dealing with patient-returned / unwanted medicines (England). 2020. Available from: <https://www.npa.co.uk/wp-content/uploads/2020/05/COVID-19-guidance-on-dealing-with-patient-returned-medicines-ENGLAND-May-2020.pdf>
- ²⁶ Gardiner D. NHS Blood and Transplant feedback: correspondence to Hospice UK. 12.07.2020 and 01.07.2022.
- ²⁷ Organ Donation (Deemed Consent) Act 2019: Section 1(4) England. London: Stationery Office; 2019. Available from: <http://www.legislation.gov.uk/ukpga/2019/7/enacted>
- ²⁸ Human Tissue Authority. Code of Practice on the Human Transplantation (Wales) Act 2013 [Updated May 2020] Available from: <https://www.hta.gov.uk/guidance-professionals/codes-practice-standards-and-legislation/codes-practice>
- ²⁹ Human Tissue Authority. Codes of practice. [Internet] Available from: <https://www.hta.gov.uk/guidance-professionals/codes-practice-standards-and-legislation/codes-practice>
- ³⁰ Academy of Medical Royal Colleges. A code of practice for the diagnosis and confirmation of death. London: Academy of Medical Royal Colleges; 2008. Available at: <https://www.aomrc.org.uk/reports-guidance/ukdec-reports-and-guidance/code-practice-diagnosis-confirmation-death/>
- ³¹ Hospice UK. 5th edition of care after death: registered nurse verification of expected adult death (RNVoEAD) guidance. 5th ed. London: Hospice UK; 2022. To request a copy, please contact clinical@hospiceuk.org
- ³² Gardiner D.NHS Blood and Transfusion feedback correspondence to Hospice UK. 12.07.2020
- ³³ Hospice UK. 5th edition of care after death: registered nurse verification of expected adult death (RNVoEAD) guidance. 5th ed. London: Hospice UK; 2022. To request a copy, please contact clinical@hospiceuk.org
- ³⁴ NHS Education for Scotland. Guidance and supporting resources for practitioners undertaking the Confirmation of Death procedure in Scotland. Edinburgh: NHS Education for Scotland; 2020. Available from: <https://learn.nes.nhs.scot/28679/coronavirus-covid-19/death-and-bereavement/guidance-and-supporting-resources-for-practitioners-undertaking-the-confirmation-of-death-procedure>
- ³⁵ Public Health (Control of disease) Act 1984, Part III Disposal of dead bodies s.46. London: The Stationery Office; 1984. Available from: <https://www.legislation.gov.uk/ukpga/1984/22/section/46>
- ³⁶ Funeral Guide. What is a pauper's funeral? Public health funerals explained. [Internet] 2020. Available from: <https://www.funeralguide.co.uk/help-resources/arranging-a-funeral/what-is-a-paupers-funeral-public-health-funerals-explained>
- ³⁷ Raymond C. Services a death doula provides. [Internet] 2020. [Updated 26 Feb 2020] Available from: <https://www.verywellhealth.com/what-is-a-death-doula-1132512>
- ³⁸ Manara A. Academy of Medical Royal Colleges feedback correspondence to Hospice UK.10.07.2020 and 01.07.2022. (Permission sought July 2022).
- ³⁹ NHS Blood and Transplant. Cornea donation. [Internet] 2020. Available from: <https://www.organdonation.nhs.uk/helping-you-to-decide/about-organ-donation/get-the-facts/cornea-donation/>
- ⁴⁰ Department of Health and Social Care. Novel coronavirus (COVID-19) standard operating procedure: Running a medicines re-use scheme in a care home or hospice setting. 2020 (now withdrawn).

- ⁴¹ National Pharmacy Association (2020) COVID-19: guidance on dealing with patient-returned / unwanted medicines (England). Available from: <https://www.npa.co.uk/wp-content/uploads/2020/05/COVID-19-guidance-on-dealing-with-patient-returned-medicines-ENGLAND-May-2020.pdf>
- ⁴² National Pharmacy Association (2020) COVID-19: Guidance on dealing with patient-returned / unwanted medicines (England). Appendix 1: checklist on pharmacy considerations of accepting unwanted medicines Available from: <https://www.npa.co.uk/information-and-guidance/covid-19-unwanted-medicines/>
- ⁴³ Ministry of Justice. Coroners statistics 2019: England and Wales. [Internet] 2020. [Updated 29 May 2020] Available from: <https://www.gov.uk/government/publications/coroners-statistics-2019/coroners-statistics-2019-england-and-wales>
- ⁴⁴ Crown Office & Procurator Fiscal Service. Our role in investigating deaths. [Internet] [Updated 27 May 2021] Available from <https://www.copfs.gov.uk/our-priorities/fatalities-investigation#:~:text=In%20over%2090%25%20of%20the%2011%2C000%20deaths%20reported,may%20take%2012%20months%20or%20longer%20to%20complete.>
- ⁴⁵ National Records of Scotland. Vital events reference tables 2019: summary. [Internet] Available at: <https://www.nrscotland.gov.uk/files//statistics/nrs-visual/ve/vital-events-ref-tables-19-info.pdf>
- ⁴⁶ Coroner's Service for Northern Ireland. Email correspondence to Dawn Hart, Hospice UK 29.07.2020
- ⁴⁷ Care Quality Commission. Statutory notification. Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983. [Internet] [Updated 12 May 2022] Available from: [https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-notification-death-or-unauthorised-absence#:~:text=Care%20Quality%20Commission%20\(Registration\)%20Regulations, follow%20Dup%20action%20where%20needed](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-notification-death-or-unauthorised-absence#:~:text=Care%20Quality%20Commission%20(Registration)%20Regulations, follow%20Dup%20action%20where%20needed)
- ⁴⁸ Department of Health and Social Care. Care and support statutory guidance. [Internet] 2022 [Updated 16 June 2022] Available from: <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#contents>
- ⁴⁹ HM Passport Office. Completing a medical certificate of cause of death (MCCD). 2018 [Updated 25 March 2022] [Internet] Available from: <https://www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death>
- ⁵⁰ Coronavirus Act 2020, s1(18-21) [Registration of deaths and still births etc.] London: The Stationery Office; 2020. Available from: <http://www.legislation.gov.uk/ukpga/2020/7/contents>
- ⁵¹ Certification of death (Scotland) Act 2011, Referral of medical certificates of cause of death review, s.4 . London: The Stationery Office; 2011 Available from: <https://www.legislation.gov.uk/asp/2011/11/section/4#:~:text=%20Certification%20of%20Death%20%28Scotland%29%20Act%202011%20, under%20subsection%20%281%29%20%28other%20than%20one...%20More%20>
- ⁵² Ministry of Justice. Medical practitioners: guidance on completing cremation forms. [Internet] 2012 [Updated 25 March 2022] Available from: <https://www.gov.uk/government/publications/medical-practitioners-guidance-on-completing-cremation-forms>
- ⁵³ Department of Health. [NI] Guidance surrounding death. [Internet] Available from: <https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/guidance-surrounding-death>
- ⁵⁴ National Records of Scotland. Registration of deaths and still-births. [Internet] Available from: <https://www.nrscotland.gov.uk/registration/registering-a-death>
- ⁵⁵ British Medical Association. COVID-19 death certification and cremation. [Internet] [Last reviewed 13 April 2022] Available from: <https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-death-certification-and-cremation>
- ⁵⁶ Scottish Government. Verification of death by a registered healthcare professional: Chief Nursing Officer guidance. [Internet] 2017. Available from: <https://www.gov.scot/publications/verification-of-death-by-a-registered-healthcare-professional-chief-nursing-officer-guidance/>
- ⁵⁷ Beattie J. ICD deactivation at the end of life: Principles and practice: a discussion document for healthcare professionals. [London]: British Heart Foundation; 2013 Available from: <https://www.bhf.org.uk/informationsupport/publications/living-with-a-heart-condition/icd-deactivation-at-the-end-life>
- ⁵⁸ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID 19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>

- ⁵⁹ Suleman M, Asaria M, Haque E, Safdar M, Shafi S, Sherif J. Elderly and end of life care for Muslims in the UK. The Muslim Council of Britain; 2019. Available from: https://mcb.org.uk/wp-content/uploads/2019/08/MCB_ELC_Web.pdf
- ⁶⁰ Lavery D. Personal communication from National Association of Funeral Directors. 2020
- ⁶¹ NHS Blood and Transplant. What can you donate? [Internet] Available from: <https://www.organdonation.nhs.uk/helping-you-to-decide/about-organ-donation/what-can-you-donate/>
- ⁶² Academy of Medical Royal Colleges. A code of practice for the diagnosis and confirmation of death. London: Academy of Medical Royal Colleges; 2008. Available at: <https://www.aomrc.org.uk/reports-guidance/ukdec-reports-and-guidance/code-practice-diagnosis-confirmation-death/>
- ⁶³ Hospice UK. 5th edition care after death: registered nurse verification of expected adult death (RNVoEAD) guidance. London: Hospice UK; 2022. To request a copy, please contact clinical@hospiceuk.org
- ⁶⁴ Association of Ambulance Chief Executives. JRCALC [Joint Royal Colleges Ambulance Liaison Committee] Clinical practice guidelines [Internet] Available from: <https://aace.org.uk/clinical-practice-guidelines/>
- ⁶⁵ Department of Health and Social Care. Coronavirus (Covid-19): verifying death in times of emergency. [Internet] 2020 [Published 05 May 2020] Available at: <https://www.gov.uk/government/publications/coronavirus-covid-19-verification-of-death-in-times-of-emergency/coronavirus-covid-19-verification-of-death-in-times-of-emergency>
- ⁶⁶ Royal College of General Practitioners & British Medical Association. Guidance for remote verification of expected death (VoED) out of hospital. British Medical Association; 2020 Available from: <https://www.bma.org.uk/media/2323/bma-guidelines-for-remote-voed-april-2020.pdf>
- ⁶⁷ NHS Education for Scotland. Guidance and supporting resources for practitioners undertaking the Confirmation of Death procedure in Scotland. Edinburgh: NHS Education for Scotland; 2020. Available from: <https://learn.nes.nhs.scot/28679/coronavirus-covid-19/death-and-bereavement/guidance-and-supporting-resources-for-practitioners-undertaking-the-confirmation-of-death-procedure>
- ⁶⁸ Human Rights Act 1998 (Article 2) London: HMSO. Available at: <https://www.legislation.gov.uk/ukpga/1998/42/schedule/1>
- ⁶⁹ NHS England and NHS Improvement. Coronavirus Act: excess death provisions: information and guidance for medical practitioners. [Internet] 2020 Available from: <https://www.england.nhs.uk/coronavirus/documents/coronavirus-act-excess-death-provisions-information-and-guidance-for-medical-practitioners/>
- ⁷⁰ National Records of Scotland. Registration of deaths and still-births. [Internet] Available from: <https://www.nrscotland.gov.uk/registration/registering-a-death>
- ⁷¹ Hucker R. Royal College of Pathologists feedback correspondence to Hospice UK. 28.08.2020
- ⁷² National Medical Examiner. Implementing the medical examiner system: national medical examiner's good practice guidelines. NHS England and NHS Improvement; 2020. Available from: https://improvement.nhs.uk/documents/6398/National_Medical_Examiner_-_good_practice_guidelines.pdf
- ⁷³ Local Government Association. COVID-19 flow chart for death registration process. [Internet] 2020 Available from: <https://www.local.gov.uk/covid-19-flow-chart-death-registration-process>
- ⁷⁴ NHS England. Living with COVID-19: visiting healthcare inpatient settings principles. [Internet] 2022 [Version 5, updated 07 June 2022] Available from: <https://www.england.nhs.uk/coronavirus/documents/c1606-living-with-covid-19-visiting-healthcare-inpatient-settings-principles/>
- ⁷⁵ Association for Palliative Medicine of Great Britain and Ireland. COVID-19 and palliative, end of life and bereavement care in secondary care: role of the specialty and guidance to aid care [v.4] [Internet] 2020 [Updated 20 April 2020] Available from: <https://apmonline.org/>
- ⁷⁶ Taylor E. How best to communicate bad news over the telephone. End of Life Care. 2007; 1(1): 30-37
- ⁷⁷ Hospice UK. Caring for someone dying with COVID-19 at home [Internet] 2020. Available from: <https://www.hospiceuk.org/information-and-support/i-need-covid-19-advice/caring-someone-dying-covid-19-home>
- ⁷⁸ Royal College of General Practitioners. The Daffodil Standards. [Internet] Available from: <https://www.rcgp.org.uk/daffodilstandards>
- ⁷⁹ Health Education England. Giving news of a death to a loved one – telephone checklist for healthcare staff. [Internet] 2020 Available from: https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_45016_45125_46696_52115&programmeld=45016

- ⁸⁰ Tuffrey-Wijne I. & Hollins S. When someone dies from coronavirus: a guide for family and carers. London: Beyond Words Available from: <https://booksbeyondwords.co.uk/coping-with-coronavirus>
- ⁸¹ Child Bereavement UK. Telling a child that someone has died. [Internet] Available from: <https://www.childbereavementuk.org/telling-a-child-that-someone-has-died>
- ⁸² General Medical Council. Confidentiality: disclosing information about serious communicable diseases. [Internet] Available from: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---disclosing-information-about-serious-communicable-diseases>
- ⁸³ Health and Safety Executive. Managing infection risks when handling the deceased: guidance for the mortuary, post-mortem room and funeral premises, and during exhumation. HSE; 2018 Available from: <https://www.hse.gov.uk/pubns/books/hsg283.htm>
- ⁸⁴ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID-19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>
- ⁸⁵ UK Health Security Agency. COVID-19: information and advice for health and care professionals. [Internet] [Updated 27 May 2022] Available from: <https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals>
- ⁸⁶ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID-19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>
- ⁸⁷ Nursing & Midwifery Council. The code: professional standards of practice and behaviour for nurses, midwives and nursing associates. London: NMC; 2015 [Updated 10 Oct 2018] Available from: <https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>
- ⁸⁸ Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Guidelines for the blood transfusion services: 21.2: retrieval. [Internet] [Updated 12 Jan. 2021] Available from: <https://www.transfusionguidelines.org/red-book/chapter-21-tissue-banking-tissue-retrieval-and-processing/21-2-retrieval>
- ⁸⁹ Chappell A. Viewing the body after bereavement due to a traumatic death: qualitative study in the UK. BMJ. 2010; 340:c2032, doi:10.1136/bmj.c2032
- ⁹⁰ Association for Palliative Medicine of Great Britain and Ireland.) COVID-19 and palliative, end of life and bereavement care in secondary care: role of the specialty and guidance to aid care. [v.4] [Internet] 2020 [Updated 20 April 2020] Available from: <https://apmonline.org/>
- ⁹¹ Health and Safety Executive. Handling the deceased with suspected or confirmed COVID-19. [Internet] Available from: <https://www.hse.gov.uk/biosafety/handling-the-deceased.htm>
- ⁹² Association for Palliative Medicine of Great Britain and Ireland. COVID-19 and palliative, end of life and bereavement care in secondary care: role of the specialty and guidance to aid care. [v.4] [Internet] [Updated 20 April 2020] Available from: <https://apmonline.org/>
- ⁹³ Child Bereavement UK. Supporting bereaved children and young people. [Internet] Available from: <https://www.childbereavementuk.org/supporting-bereaved-children-and-young-people>
- ⁹⁴ Child Bereavement UK. Information on viewing a body with a child. [Internet] .Available from: <https://www.childbereavementuk.org/information-viewing-a-body-with-a-child>
- ⁹⁵ Waller S, Dewar S, Masterson A, Finn H. Improving environments for care at the end of life: lessons from eight UK pilot sites. London: King's Fund; 2008. Available from: <https://www.kingsfund.org.uk/sites/default/files/improving-environments-care-at-end-of-life-eight-uk-pilot-sites-waller-dewar-masterson-finn-april-2008.pdf>
- ⁹⁶ Public Health England. Faith at end of life: a resource for professionals, providers and commissioners working in communities. London: Public Health England; 2016 Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496231/Faith_at_end_of_life_-_a_resource.pdf
- ⁹⁷ Tuffrey-Wijne I. How to break bad news to people with intellectual disabilities: a guide for carers and professionals. London: Jessica Kingsley Publisher; 2013
- ⁹⁸ NHS National Services Scotland. National infection prevention and control manual. Chapter 1: Standard infection control precautions. [Internet] [Updated 10 May 2022] Available from: <https://www.nipcm.scot.nhs.uk/chapter-1-standard-infection-control-precautions-sicps/>
- ⁹⁹ Public Health England (2020) COVID-19: infection prevention and control guidance. Available at: <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/>

- ¹⁰⁰ NHS England and NHS Improvement. National infection prevention and control. [Internet] Available from: <https://www.england.nhs.uk/publication/national-infection-prevention-and-control/>
- ¹⁰¹ Every Mind Matters. 9 tips to help if you are worried about COVID-19. [Internet] Available from: https://www.nhs.uk/oneyou/every-mind-matters/coronavirus-covid-19-anxiety-tips/?WT.tsrc=Search&WT.mc_id=Corona&gclid=EAlaIqobChMI2Mfi9ong6QIVjbHtCh3DHAX5EAAYASAAEgli4fD_BwE
- ¹⁰² Every Mind Matters. 9 tips to help if you are worried about COVID-19. [Internet] Available from: https://www.nhs.uk/oneyou/every-mind-matters/coronavirus-covid-19-anxiety-tips/?WT.tsrc=Search&WT.mc_id=Corona&gclid=EAlaIqobChMI2Mfi9ong6QIVjbHtCh3DHAX5EAAYASAAEgli4fD_BwE
- ¹⁰³ Hospice UK. Care after death: guidance for staff responsible for care after death. 3rd.ed. London: Hospice UK; 2020. To request a copy, please contact clinical@hospiceuk.org
- ¹⁰⁴ National Palliative and End of Life Care Partnership. Ambitions for palliative and end of life care: a national framework for local action, 2021-2016. National Palliative and End of Life Care Partnership; 2021.
- ¹⁰⁵ Hockley J. Learning, support and communication for staff in care homes: outcomes of reflective debriefing groups in two care homes to enhance end of life care. International Journal for Older People Nursing. 2014; 9(2):118-130.
- ¹⁰⁶ NHS England and NHS Improvement (2018) Quality, Service Improvement and Redesign Tools: After action review. Available from: <https://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-after-action-review.pdf>
- ¹⁰⁷ Point of Care Foundation. About Swartz Rounds. [Internet] Available from: <https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/>
- ¹⁰⁸ Point of Care Foundation. Team Time. [Internet] Available from: <https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/team-time/>
- ¹⁰⁹ Human Tissue Authority. Guidance on HTA Reportable Incidents (HTARIs) in the post mortem sector. HTA; 2020. Available from: <https://www.hta.gov.uk/guidance-professionals/regulated-sectors/post-mortem/post-mortem-hta-reportable-incidents-htaris>
- ¹¹⁰ National Quality Board. National Guidance on learning from deaths: a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care. [Internet] 2017 Available from: <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>
- ¹¹¹ Royal College of General Practitioners. [Daffodil Standards]: Quality improvement criteria guidance. [Internet] Available from: <https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/daffodil-standards/quality-improvement-criteria-guidance.aspx>
- ¹¹² Ministry of Justice. A guide to coroner services for bereaved people. [Internet] 2020. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859076/guide-to-coroner-services-bereaved-people-jan-2020.pdf
- ¹¹³ Crown Office & Procurator Fiscal Service. Reporting deaths to the Procurator Fiscal: information and guidance for medical practitioners. [Internet] 2015 [Revised May 2019] Available from: <https://www.copfs.gov.uk/images/Documents/Publications/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%20-%20Info%20for%20Medical%20Practitioners%20May%202019.pdf>
- ¹¹⁴ Department of Justice. Coroners service for Northern Ireland. [Internet] Available from: <https://www.justice-ni.gov.uk/articles/coroners-service-northern-ireland>
- ¹¹⁵ Association for Palliative Medicine of Great Britain and Ireland. COVID-19 and palliative, end of life and bereavement care in secondary care: role of the speciality and guidance to aid care. [Internet] 2020 [Version 4, 20 April 2020] Available from: <https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-22-March-2020.pdf>
- ¹¹⁶ UK Health Security Agency. Notifiable diseases and causative organisms: how to report. [Internet] [Updated 09 June 2021] Available from: <https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#list-of-notifiable-diseases>
- ¹¹⁷ UK Health Security Agency. Guide to donning and doffing PPE: droplet precautions: for health and social care settings. [Internet] 2020 [Version 1] Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1044504/COVID-19_Non_AGP_Donning_and_doffing_PPE_droplet_precautions.pdf

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