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Management of Deceased Patients Policy

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0.2	13/11/2017	Dr Steven Dykes	D	Document updated following EIA, and feedback from CGG, and South Yorkshire Police
1.0	07/02/2018	Dr Steven Dykes	A	Approved at TMG
1.1		Dr Steven Dykes	D	Updated with new definitions of conditions unequivocally associated with death in children younger than 18 years
2.0	28/05/2020	Steven Dykes	D	Updated following consultation with North Yorkshire and West Yorkshire Police and Coroners Offices
2.0	Nov 2020	Ruth Parker	A	Approved by TMG
2.1	June 2023	Risk Team	A	TMG approved extension until November 2023
2.2	December 2023	Steven Dykes	D	Circulated draft for internal and external consultation
2.3	May 2024	Risk Team	D	Policy formatted to Trust new visual identity.
3.0	May 2024	Risk Team	A	Policy approved within May 2024 Clinical Governance Group.
A = Approved D = Draft				
Document Author – Dr Steven Dykes Deputy Medical Director				
Associated Documentation: Resuscitation Policy Safeguarding Policy (Children, Young People and Adults at Risk) Mortuary Pathway Procedure West Yorkshire Police and YAS Attendance at Death Procedure North Yorkshire Police and YAS Attendance at Death Procedure				

Staff Summary

The nature of the death, where the death has occurred, and the context in which it has occurred effects what needs to happen and who needs to be informed.
Once verification has confirmed the patient as deceased, clinicians must provide care for the deceased's relatives and depending on the circumstances inform the deceased patient's own medical practitioner/GP and/or the police if required.
Only in exceptional circumstances will YAS transport deceased patients.
All unexpected deaths must be referred to police – In some areas a police officer will always attend and in some areas a remote decision will be made on attendance or not – please refer to local procedures.
The police provide the most appropriate route for ambulance clinicians to refer cases to the coroner; however, the patient's own GP will refer the case to the coroner if they are unable to complete a medical certificate of the cause of death.
From September 2024 there is a statutory requirement that all deaths that are not referred directly to a coroner are independently scrutinised by a Medical Examiner. This referral will be made by the doctor or by the mortuary/funeral home.
All deceased children (child is defined as a person under 18 years old) meeting the criteria for a Joint Agency Response should be transferred to the nearest appropriate Emergency Department to enable the JAR to be triggered. The default position for any child death should always be to attend the Emergency Department, but with older children where the cause of death is more apparent (for example, stabbing), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the Force Incident Manager (FIM)

1.0 Introduction

1.1 Caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right.

2.0 Purpose/Scope

2.1 This policy is applicable to all YAS staff who have a responsibility for providing care to deceased patients.

2.2 Care after death includes:

- Honouring the spiritual or cultural wishes of the deceased person and their family/carers whilst ensuring legal obligations are met.
- Ensuring that the privacy and dignity of the deceased person is maintained.
- Ensuring the health and safety of everyone who encounters the body is protected.

3.0 Background

3.1 The nature of the death, where the death has occurred, and the context in which it has occurred effects what needs to happen and who needs to be informed.

3.2 For example, some deaths are expected or peaceful while others may be sudden or traumatic. As a result, families and carers are likely to have a range of responses and needs and each may also have differing views about how the person should be cared for after death. YAS clinicians should respect the wishes of the patient and relatives following death unless there is a legal requirement to do otherwise.

3.3 Once verification has confirmed the patient as deceased, clinicians must provide care for the deceased's relatives and depending on the circumstances inform the deceased patient's own medical practitioner/GP and/or the police if required. Only in exceptional circumstances will YAS transport deceased patients.

3.4 Not all deaths have to be reported to the coroner. In most cases the deceased's own doctor who was treating them will be able to supply a medical certificate of the cause of death. But some deaths must be reported to the coroner. The coroner is an independent judicial officer appointed to investigate all sudden, violent and unexplained deaths of persons who have either died in, or whose bodies are brought into, the area. In certain cases, the coroner must hold an inquest to determine who, when where and how the deceased came by their death. Referral to the coroner is required.

- When no doctor has treated the deceased during his or her last illness, or
- When the doctor attending the patient did not see him or her within 28 days before death, or after death, or
- When the death occurred during an operation or before recovery from the effect of an anaesthetic or
- When the death was sudden and/or unexplained or attended by suspicious circumstances, or
- When the death might be due to an industrial injury or disease, or to accident, violence, neglect or abortion, or to any kind of poisoning, or
- When the death occurred in prison or in police custody

3.5 The Police provide the most appropriate route for ambulance clinicians to refer cases to the coroner; however, the patient's own GP can refer the case to the coroner if they are unable to complete a medical certificate of the cause of death.

3.6 The Police must always be contacted:

- Where the circumstances of the death cannot be explained
- If the deceased is under 18 years of age
- If the identity of the deceased cannot be confirmed
- Where death did not occur in the home of the deceased or relative of the deceased *(home includes residential home and gardens / yards etc.)*
- If there is no known General Practitioner (GP) for the deceased
- Where a relative/other responsible person is not easily contactable
- If there are obvious physical signs of trauma or apparent deliberate violence
- Where there are signs of forced entry
- Deaths caused as a result of industrial or agricultural accidents and work-related. deaths
- Suspected Suicides
- Suspected Drug related deaths
- Deaths as a result of drowning including diving deaths.
- Deaths in police or prison custody whilst serving a custodial sentence or if
- lawfully detained in any institution
- Deaths on the railway (responsibility of British Transport Police)

- Deaths at MOD Establishments
- Deaths as a result of fires
- Fatal road traffic collisions

3.7 From September 2024 there is a statutory requirement that all deaths that are not referred directly to a coroner are independently scrutinised by a Medical Examiner. This referral will be made by the doctor or by the mortuary/funeral home. Medical Examiners are senior doctors who are based at hospitals and their role is to agree the proposed cause of death and accuracy of the medical certificate with the doctor completing it, discuss the cause of death with relatives and establish if you have any questions or concerns with care before death and act as a medical advice resource for the local coroner. The Medical Examiner may refer the death to the coroner if there are any concerns about care before death.

3.8 **Recognition of Life Extinct (ROLE)**

3.8.1 Verification of death and termination of resuscitation is detailed in the JRCALC clinical guidelines.

3.9 **Expected death or death is not unexpected.**

3.9.1 This occurs where a death was anticipated, expected, and predicted and there are no unusual circumstances, and the person has been assessed by a doctor or healthcare professional either remotely or in person during their last illness and within the last 28 days of life. In most cases, the patient's GP will certify the death and issue a Medical Certificate of Cause of Death (MCCD).

3.9.2 If the death occurs in the patient's own home, YAS will not usually attend, and the patient's own GP or out of hours doctor or practitioner would be asked to attend. However, if YAS clinicians are on scene, the deceased's own GP should be notified directly in-hours or via ePR Post Event Messaging out of hours. If the death occurred in a care home, or if the family or responsible adult are present, they can arrange a funeral director to attend and there is no requirement for the ambulance clinician to remain on scene.

3.9.3 It is the responsibility of the doctor with whom the deceased was registered to deal with the death certification procedure. The out-of-hours primary care service will be unable to complete the death certificate.

3.10 **Unexpected ("sudden") deaths**

3.10.1 The management of unexpected deaths will differ depending on which coronial area the patient has died in. Deceased patients must not be transported outside the coronial area in which they died.

3.9.2 All unexpected deaths must be referred to police – In some areas a police officer will always attend and in some areas a remote decision will be made on attendance or not – please refer to local procedures.

3.9.2 YAS would not normally transport the deceased patient and should only be considered in exceptional circumstances. YAS will not respond to body recovery requests from the police. Transport arrangements will depend on prior agreement with the coroner but may involve removal of the deceased to an agreed funeral director or mortuary.

3.10 Death in unusual or suspicious circumstances

3.10.1 When unusual or suspicious circumstances are present all reasonable precautions to preserve the potential crime scene should be taken and the Police called to attend.

3.10.2 In cases where an adult dies and abuse or neglect, whether known or suspected could be a contributory factor and there is concern that partner agencies could have worked more effectively to protect the adult, the YAS safeguarding team should be informed via the generic secure email address yas.safeguard@nhs.net The safeguarding team should inform the local safeguarding adults board in line with S.44 of the Care Act 2014 so that consideration can be given to whether the case meets the threshold for a Safeguarding Adults Review (SAR).

4.0 Process

4.1 Patient Transport Service – See PTS SOP

4.2 NHS 111 – see the Expected/Unexpected SOP

4.3 999/Emergency Operations Centre

4.3.1 All calls will be processed using The International Academy Medical Priority Dispatch System (AMPDS) or NHS Pathways. Resuscitation will be commenced unless the caller informs the call taker that the patient is beyond any help or the caller is certain that we should not try to resuscitate the patient.

4.3.2 Obvious death will only be unquestionable in the following situations;

- Cold and stiff in a warm environment
- Decapitation
- Decomposition
- Incineration

4.3.3 Expected death determinant will be used when a valid Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order is offered. If a DNACPR is in place, but the caller believes the DNAR should be ignored or is uncertain the DNACPR is valid, an appropriate response and resuscitation attempt will be made. DNACPR is not valid when the patient experiences a cardiac arrest due to a reversible condition such as choking, overdose or trauma.

4.4 Death in the ambulance

4.4.1 When a patient with a DNACPR dies during transport in an ambulance the patient can be taken to an appropriate destination. If there is any doubt on if the death is expected or not, the procedure for unexpected deaths must be followed and the patient must not be transported outside the coronial area in which they died. Non-Emergency Patient Transport Service staff must follow agreed local procedure before moving the patient. The preferred location may be documented in any end-of-life care plan, or patients stated preference, if not the following guidance may be used:

Transport between hospital and home	Take to hospital mortuary
Transport between hospice and home	Return to hospice
Transport between hospital and hospice	Take to hospital mortuary

Transport between hospice and hospital	Return to hospice
Transport between home and hospital	Take to mortuary
Transport between home and hospice	Continue to hospice
Transport to nursing home from home address	Take to nursing home

4.4.2 The receiving location must be contacted to notify them of the death and to accept the body. It is the responsibility of YAS staff to inform the sending and receiving location of the patient death and inform the patient's own GP of the death and destination of the body.

4.5 Children

4.5.1 The national JRCALC guidelines detail the management of a child death. Resuscitation should always be attempted unless there is a condition unequivocally associated with death or a valid advance decision/Limitation of Treatment Agreements (LOTA)/ReSPECT confirming that the clinician should not attempt resuscitation. In most circumstances if the clinician has confirmed death, it will still be appropriate to transfer the child and family to an Emergency Department with paediatric facilities where the Joint Agency Response (JAR) may be initiated. An exception might be an expected death of a child and where the LOTA gives advice to remain at home or transport to a hospice or other facility.

4.5.2 If the death is sudden and unexpected with no immediate apparent cause, where the initial circumstances raise suspicions that the death may not be natural, could be due to external causes, occurs in custody or whilst detained under the Mental Health Act – or a stillbirth with no healthcare professional in attendance then a JAR will be initiated.

4.5.3 All deceased children (child is defined as a person under 18 years old) meeting the criteria for a JAR should be transferred to the nearest appropriate Emergency Department to enable the JAR to be triggered. The default position for any child death should always be to attend the Emergency Department, but with older children where the cause of death is more apparent (for example, stabbing), a decision may be made to transfer straight to mortuary facilities or to remain in situ at the crime scene to allow other forensic processes to take place under the guidance of the Force Incident Manager (FIM).

4.5.4 All child deaths should be escalated to the YAS safeguarding team along with the social care referral details via the generic secure email address yas.safeguard@nhs.net to enable prompt analysis and participation in statutory review processes.

4.6 Management of indwelling devices after death

4.6.1 If possible, remove any devices (e.g. LMA, ETT) for dignity purposes, however in cases of unexpected death once verification of death has been undertaken, all invasive devices (endotracheal tube, intravenous cannulae etc.) must be left in situ. Any monitoring/ defibrillator electrodes must also be left in place. Do not wash the body or begin mouth care in case it destroys evidence.

4.7 Booking into the mortuary – See the Mortuary Pathway Procedure

4.7.1 It is the responsibility of the admitting ambulance clinician to have sought a positive identification of the deceased. If identification is not possible or identification is not

certain, the police must be contacted. On arrival at the mortuary the YAS clinician must ensure the patient is tagged, and the local procedure followed.

5.0 Implementation Plan

5.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

6.0 Monitoring compliance with this Policy

6.1 Incidents and complaints logged on the Datix system will be reviewed for issues relating to management of the deceased.

7.0 Appendices

Appendix A - Definitions

- Expected Death

  Those whereby the GP/Consultant/Medical Officer concerned has diagnosed the patient as suffering from an advanced, progressive, incurable disease and has died due to the consequences of the disease.

- Unexpected Death (definitions below only to be used in North and West Yorkshire)

  Natural causes – a death that appears to have resulted from the normal progression of a naturally occurring disease, for example: heart disease; cancer; old age

  Unnatural causes - the death may be as a result of the actions of the deceased or of a 3rd party, for example: murder / manslaughter; drugs death; suicide; trauma; injury.

- Responsible Person

  Definition of Responsible or Competent Person

  - One who is able to understand the information relevant to the decision.
  - One who is able to retain that information.
  - One who is able to use or weigh that information as part of the process of making the decision.
  - One who is able to communicate their decision by using any recognisable means of communication.
  - The factors that will determine that the individual is capable of looking after the patient are:
    - Has access to a telephone.
    - Knows the patients General Practitioners contact details.
    - Is able to communicate with the emergency services.

Appendix B - Roles & Responsibilities

All Patient Facing Staff
All patient facing staff must work to their scope of practice when undertaking decisions on withholding or terminating resuscitation and verification of death. All decisions must be compliant with JRCALC Ambulance Clinical Practice Guidelines. All staff must fully document all rationale and decisions taken on the patient report form. All patient facing staff have a responsibility to follow this policy

Clinical Business Unit Leadership Teams
Consultant Practitioners are responsible for joint working with local police forces, coroners and NHS system partners on local procedures and pathways regarding deceased patients. Any changes to the management of deceased patient procedures and pathways must be approved at the Trusts Clinical Governance Group

Deputy Medical Director
The Deputy Medical Director is responsible for ensuring this policy is compliant with national policy and legislation and kept up to date.

Clinical Governance Group
Clinical Governance Group is the responsible group for approving this policy and any associated procedures and pathways.