Leicestershire Partnership NHS Trust

Verification and Certification of Death Policy

Clinical Policy

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Leicestershire Partnership NHS Trust

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Leicestershire Partnership NHS Trust

1.0 Quick Look Summary

This policy sets out the parameters and procedures for registered nurses in the verification of death and how deaths are certified.

This policy has been developed to determine the scope of nursing practice regarding the verification of patient death, and the prompt certification of death to enhance continuity of end-of-life care for patients, their families, relatives, and significant others.

In line with One Chance to Get it Right (Leadership Alliance for the Care of Dying People 2015); Verification of expected death in childhood (Together for Short Lives 2012); and NICE Quality Standard (2017) on care of dying adults in the last days of life, it is appropriate for registered nurses to be able to formally verify the expected death of their patients, and thus improve the quality of care to families at this difficult time, which will include the permission to remove the body to an undertaker.

Verification of death sometimes referred to as pronouncing death or confirming death is the procedure of determining whether a person is deceased. All deaths should be subject to verification that life has ended.

The verification of death must be recorded (appendix 2). Death can be verified by all doctors and in defined situations, with appropriate training and competence, by registered nurses (NMC 2015; Secretary of State for the Home Department 2003). Out of Hour (-OOH) doctors can verify death over the telephone if not able to visit the site.

Verification of death is separate to the certification process.

RNV0EAD 5th Edition
Updated final version

1.1 Version Control and Summary of Changes

Version number	Date	Comments
Version 1	Feb 2016	Updated Guidance: This policy replaces the Verification of Adult Expected Death by a Registered Nurse or Emergency Care Practitioner (ECP) who holds State Registration as either a Paramedic or Nurse (NP015 Leicestershire County and Rutland Policy 2010)
Version 1.3	June 2016	To include verification of expected death by registered nurses for children.
Version 1.4	July 2016	Amendments from guidance to policy standards
Version 1.5	August 2016	Separation of verification of expected death within children's; adult mental health; learning difficulties and community care services from verification of death within community in patient areas for CHS.
Version 1.6	August 2016	Addition to patient's home in section 4.5 /4.6 and 4.7
Version 1.7	August 2016	Addition of definition of invasive procedure.
Version 1.8	August 2016	Inclusion of ANP and medical certification guidance.
Version 1.9	August 2016	Expansion of the certification to community hospital nurses and ANPs
Version 1.10	Sept 2016	Amendments to include Emergency Health Care Plans and guidance for Children's nurses
Version 1.11	Sept 2016	Inclusion of certification of death to policy title and content
Version 1.12	June 2019	Amendments include removal of DOLs and informing the Coroner from Appendix 2. Update of Due Regard screening template and addition of Data Privacy Impact Assessment screening tool.
Version 1.13	May 2023	Amendments include inclusion of Medical Examiner process & ReSPECT form. Removal of: If the death occurred within 24 hours of admission to a community-based bed (including nursing and residential care) unless there is a definitive diagnosis or specific end of life care plan such as a personalised care plan 'deciding right form' plus a signed ReSPECT/ DNAR-CPR form in place. Section 4.3 Out of Hours service (OOH) - Verify death over the telephone if not able to visit the site.

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Sarah Latham
Author(s)	Johnathon Dexter, Sue Swanson
Implementation Lead	Leon Ratcliffe
Core policy reviewer group	Ruth Tandy Advanced Nurse Practitioner Leon Ratcliffe – Head of Medical Services
Wider consultation	**Sue Arnold** **Tracy Ward** **Leon Ratcliffe** **Sarah Latham**

	Julie Potts **Kim Sanger** **Michelle Law** **Katie Willets** **Dr Rebecca Hall** **Dr Gill (Neonatology Consultant)** **Trust Policy Experts**

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
CEG/Quality Forum	Trust Board

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 6) of this policy

1.6 Definitions that apply to this Policy

Verification of death	Physiological assessment to confirm the fact of death.
Certification of death	The process of completing the 'Medical Certificate of Cause of Death' (MCCD). The MCCD can only be completed by a registered medical practitioner.
Expected death	Where discussions have taken place between the medical and nursing team, the patient and the patient's relatives, and a decision has been made and documented that no further intervention is appropriate.
DNAR-CPR Form	Do Not Attempt Cardio- Pulmonary Resuscitation form (East Midlands) is a formal declaration that cardio-pulmonary resuscitation should not be attempted.
DoLS	Deprivation of Liberty Safeguard
ANP	Advanced Nurse Practitioner
GP	General Practitioner
NMC	Nursing and Midwifery Council
OOH	Out of Hours
PRPs/EHCP	Personal Resuscitation Plans/Emergency Health Care Plans are agreed plans that families, children, and professionals sign up to about the interventions that the child will receive with regards to the different health presentations.
ReSPECT	The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. (https://www.resus.org.uk/respect) These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.
RN	Registered Nurse
Post invasive procedure	After a procedure that, makes a cut or hole to gain access to patient's body or gains access to a body cavity without requiring a cut or; use of electromagnetic radiation.

2.0. Purpose and Introduction

2.1 To provide a framework within which registered nurses may safely verify a death, without an unnecessary and potentially distressing delay and sets out the process to enable the safe verification of death.

2.2 This policy should be read in conjunction with:

- Care of the Deceased Policy and Guidelines (LPT 2019).
- NICE Quality Standard – (QS 144) Care of dying Adults in the last days of life' (NICE 2017).
- One Chance to get it right. Leadership Alliance for the Care of Dying People 2015.
- Verification of expected death in childhood: Guidance for children's palliative

care services (Together for Short Lives 2012).
https://www.togetherforshortlives.org.uk/app/uploads/2018/01/ProRes-Verification-Of-Expected-Death-In-Childhood.pdf

- Confirmation of death | Advice guides | Royal College of Nursing (rcn.org.uk)
- 5th Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance June 2022
- Care After Death guidance | Hospice UK July 2022

3.0 Registered Nurse Verification of Death Parameters

3.1 This policy applies:

- To registered nurses working in LPT with the appropriate competency.
- To patients in receipt of LPT services.
- When a ReSPECT/ DNAR-CPR / Personal Resuscitation Plan (PRP)/Emergency Healthcare Care Plan (EHCP), Advanced Care Plan is in place that indicates DNAR.

3.2 This policy does not apply:

- In cases of sudden or unexpected death (sudden or unexpected death is defined as a natural, unexpected fatal event that occurs where such an abrupt outcome could have not been predicted), when the patient is a child; or an adult within their own home; or an adult under Adult Mental Health or Learning Difficulties services. In these circumstances verification of death must not be carried out by the registered nurse.
- The death is sudden, unexpected, or circumstances give cause for concern, the registered nurse must immediately report the death to medical staff and complete related incident reporting procedures.
- If death occurs within 24 hours of admission to a community-based hospital bed and NO ReSPECT/DNAR -CPR in place
- If death has occurred/or may have been because of an incident, e.g., fall or drug error.
- If death occurs post-operatively or post invasive procedure
- If there are any suspicious circumstances related to the death.
- When the deceased was detained under the Mental Health Act (this is regarded as a ‘death in custody’). When the deceased has died in custody, as part of a custodial sentence.

- Where resuscitative measures had been initiated prior to the patient's death such as CPR.

- When an expected death has occurred at the patient's home and the registered nurse is not present or expected to imminently attend, then verification would be completed by the most appropriate Medical Practitioner, such as GP or out of hours GP service.

- Where there is a need for the urgent release of the deceased body by some relatives for burial only outside normal working hours.

3.3 The policy does apply:

- When the patient is a child; or an adult is within their own home / care home; or an adult under Adult Mental Health or Learning Disability services the registered nurse will only verify death if the death is expected. Within LPT there will be those patients whose death becomes inevitable. An expected death can be defined as 'a death where a patient's demise is anticipated soon and the doctor will be able to issue a medical certificate as to the cause of death (i.e., the doctor has seen the patient within the last 28 days before the death and this is not a case reportable to the coroner (ONS, 2022)

- When an expected death has occurred within the patient's home, and a registered nurse is in attendance, it is appropriate for the registered nurse who has achieved required competency can verify the death.

- When an expected death has occurred at the patient's home and a registered nurse is imminently due to attend, then it is appropriate for that registered nurse, who has achieved required competency, to verify the death when they arrive.

- When a death has occurred in a community hospital (CHS Directorate), it is appropriate for the registered nurse, who has achieved required competency, to verify the death.

3.4 Certification of Death: Nurses are not able to certify a death. The process for activation of the certification process within community hospitals by the nursing or ANP staff is detailed in appendix 1 of this policy.

4.0 Process Chart

Following a death, the nurse must confirm the identity of the patient using patient identification band against healthcare records.

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The nurse must determine if the patient's death and the circumstances of the death are compatible with nurse verification parameters (refer to section 4).

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Check medical history details (drugs, cataracts, false eyes)
Ensure you have a stethoscope and a pen torch to carry out verification procedure.

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Inform family / carers that you are about to commence the physical examination of the patient to ascertain that death has occurred

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Assess and confirm all the following criteria:

- No carotid / radial pulse after palpation for a minimum of 5 minutes
- No heart sounds for a minimum 5 minutes, determined by use of stethoscope using the 5 locations for cardiac auscultation.
- No respiratory effort, determined by observation, for a minimum 5 minutes
- No eye movements, Pupils are fixed and dilated.
- Pupils do not react to light, determined by shining a pen torch into a patient's eye and observing for any change in shape or size; this should be repeated in both eyes a minimum of 5 minutes
- No response to painful stimuli, such as squeezing the trapezius muscle oflexing the end knuckle of each finger.
- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest

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Record the results of the above observations within the patient healthcare records and Verification of Death Record Sheet is available for use (appendix 2).

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If assessment is inconclusive, then repeat 5 minutes later.
If death is confirmed: record date, time and name of registered nurse who verified the death in the patient healthcare records.

↓

If assessment is inconclusive, then repeat 5 minutes later.
If death is confirmed: record date, time and name of registered nurse who verified the death in the patient healthcare records.

↓

If appropriate liaise with family to enable arrangements for patient's body to be moved by the preferred undertaker / chapel of rest.

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Notify the GP / relevant clinician of the patient's death as soon as possible (within one working day)

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ANP to refer to Medical Examiner office on next working day

5.0 National Medical Examiner (ME) Process

In November 2021 it was described that a new medical examiner system was being rolled out across England and Wales to provide greater scrutiny of deaths. This information shared the following:

'The Coroners and Justice Act 2009 provides for a system of death certification under which all deaths in England and Wales that do not require investigation by a coroner will

be subject to scrutiny by independent medical examiners. The statutory scheme (as amended) provides for local authorities in England and Local Health Boards in Wales to appoint the medical examiners. The legislative provisions are not yet fully implemented.

The Government now intends that the system will be within the NHS. In 2018, the Government announced that it would amend the Coroners and Justice Act 2009, when an opportunity arose, and that, meanwhile, a non-statutory medical examiner system would be introduced. The stated purpose of the medical examiner system is to:

1 Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths.

2 Ensure the appropriate direction of deaths to the coroner.

3 Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased.

4 Improve the quality of death certification.

5 Improve the quality of mortality data.

The introduction of a system of medical examiners follows a long period of policy development, including pilot schemes, which originated, at least in part, as a response to Harold Shipman's murder of his patients. For many years, Shipman managed to escape detection by certifying patients he murdered as having died from natural causes, avoiding scrutiny by a coroner. In 2003, the Shipman Inquiry, chaired by Dame Janet Smith, proposed that there should be an effective cross-check of the account of events given by the doctor who treated the deceased and who claimed to be able to identify the cause of death, regardless of whether the death was followed by burial or cremation. Similar recommendations have also been made by others.
https://commonslibrary.parliament.uk/research-briefings/cbp-9197/

- From the 1st of April 2022 a new ME review process came into effect for all CHS Community Hospital Deaths. ANP notifies the University Hospitals of Leicester's ME's office of the death of a patient. The ME's office agrees the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it.
- The ME will discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death.
- Should any learning or good practice be identified this will be sent through to LPT's Learning from Deaths (LfD) email (lpt.learningfromdeaths@nhs.net).
- Community Hospitals deaths are recorded via an eIRF to identify and facilitate learning and improve practice and patient care.
- Following the ME process, where areas of potential learning or good practice have been identified, these will be discussed and recorded at a LfD forum meeting through presentation of the LfD review. These presentations allow discussion in greater detail and reflection with actions from the learning being implemented. Individuals that were caring for the patient are also involved allowing for real time learning and reflection.

6.0 Duties within the Organisation

Commented [HP(PNT1]: I've added the below to 6.4

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

6.1 Divisional Directors and Heads of Service are responsible for:

- Ensuring there are clear Policies and Protocols that give authority for individuals to perform the tasks and that this is reflected within their job descriptions

6.2 Service managers and matrons

- Ensuring the verification and certification of death policy is adhered to in the clinical setting and there is a clear process for dissemination
- Staff are released for training and competent in the skill of verification of expected death within LPT
- Line managers are clear in their roles and responsibilities in implementing this policy
- To act in accordance with organisational policy on the actions required of reported incidents/ concerns complaints
- Ensure that line managers are supported in monitoring compliance with the verification and certification of death policy.
- Contribute to the LfD process
- Monitor compliance with audit

6.3 Ward sisters/ Charge nurse

- Ensure all staff in their service are aware of and adhere to this policy and that there is a clear process for dissemination.
- Ensure that staff are released to meet their training needs.
- Ensure staff attend training updates and records of attendance are kept
- Ensure that all documentation is completed correctly through audit
- Ensure that staff work in line with verification of death policy
- Ensure they act in accordance with organisational policy of the reporting of incidents/ complaints/ concerns.

6.4 Responsibility of Clinical Staff

- Ensure that they are aware and adhere to the verification of death policy, accepting accountability for their own practice
- Ensure that they attend verification of death training
- Understand their role and responsibilities in verifying a death
- Maintaining their skills and competence to verify death of patients within the parameters stated in the policy.
- Participating in the investigation of incidents / concerns / complaints regarding registered nurses' compliance of this policy.
- Completing of documentation appropriate to the care setting.
- Reporting of incidents and near misses relating to verification of death.
- Undertaking / cooperating with audits of practice within the clinical setting.
- Contributing to the LfD process.

7.0 Policy, Guideline or Procedure / Protocol Author

Lead Director

Directors, Heads of Service

Are responsible for ensuring that policy is embedded throughout the directorate/ services.

Senior Managers, Matrons and Team Leads

- The implementation of this policy.
- Ensuring that registered nurses are trained and competent in the skill of verification of expected death within LPT.
- Ensuring that line managers are supported in monitoring compliance with this policy.
- Investigating incidents / concerns / complaints regarding registered nurses' compliance with this policy.
- Contributing to the LfD process.

Staff

Corporate Affairs Team

Responsibility of Clinical Staff

- Maintaining the standards in this policy and accepting accountability for their own practice.
- Maintaining their skills and competence to verify death of patients within the parameters stated in the policy.
- Participating in the investigation of incidents / concerns / complaints regarding registered nurses' compliance of this policy.
- Completing of documentation appropriate to the care setting.
- Reporting of incidents and near misses relating to verification of death.
- Undertaking / cooperating with audits of practice within the clinical setting.
- Contributing to the LfD process.

Consent

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-

verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

  - Understand information about the decision
  - Remember that information
  - Use the information to make the decision
  - Communicate the decision

8.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
Appendix 2	All registered nurses verifying death have completed the relevant training.	Appraisal. Training records.	Line Manager	Annual
4.0	All registered nurses trained are competent and confident in performing verification of death within the policy parameters.	Discussion at appraisal between line manager and staff member / clinical supervision.	Line Manager	Annual
6.0	Review of incidents / complaints / concerns by directorate to identify concerns around verification of death.	Collection of data via the safeguard system and complaints / concern reports.	Service Line Governance Groups (by exception reporting to Clinical Effectiveness Committee within highlight report).	Quarterly

9.0 References and Bibliography

- BMA, 2019. Confirmation and certification of death - Guidance for GPs in England.
- C1566-information-for-medical-practitioners-after-the-coronavirus-act-2020-expires-march-2022.pdf (england.nhs.uk)
- CQC Fundamental Care End of Life Care 2022 accessed 10/05/2023 via End of life care - Care Quality Commission (cqc.org.uk)
- Home Office (1971) Report of the committee on Death Certification and Coroners. CMND 4810. London Her Majesty Stationary Office.
- One Chance to get it right. Leadership Alliance for the Care of Dying People 2015.
- National Institute for Health and Care Excellence (NICE) Quality Standard QS144 'Care of dying adults in the last days of life'. London
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- Secretary of State for the Home Department (2003) Death Certification and Investigation in England, Wales and Northern Ireland-The Report of a Fundamental Review 2003.Cm 5831. London. Her Majesty Stationary Office.
- Skills for Health (2010) standard CHS54 'Verify an expected death accessed via https://tools.skillsforhealth.org.uk/competence/show/html/id/2231/ on 19.05.2023
- Together for Short Lives (2012) The verification of expected death in childhood. Guidance for children's palliative care services. Together for Short lives. Bristol

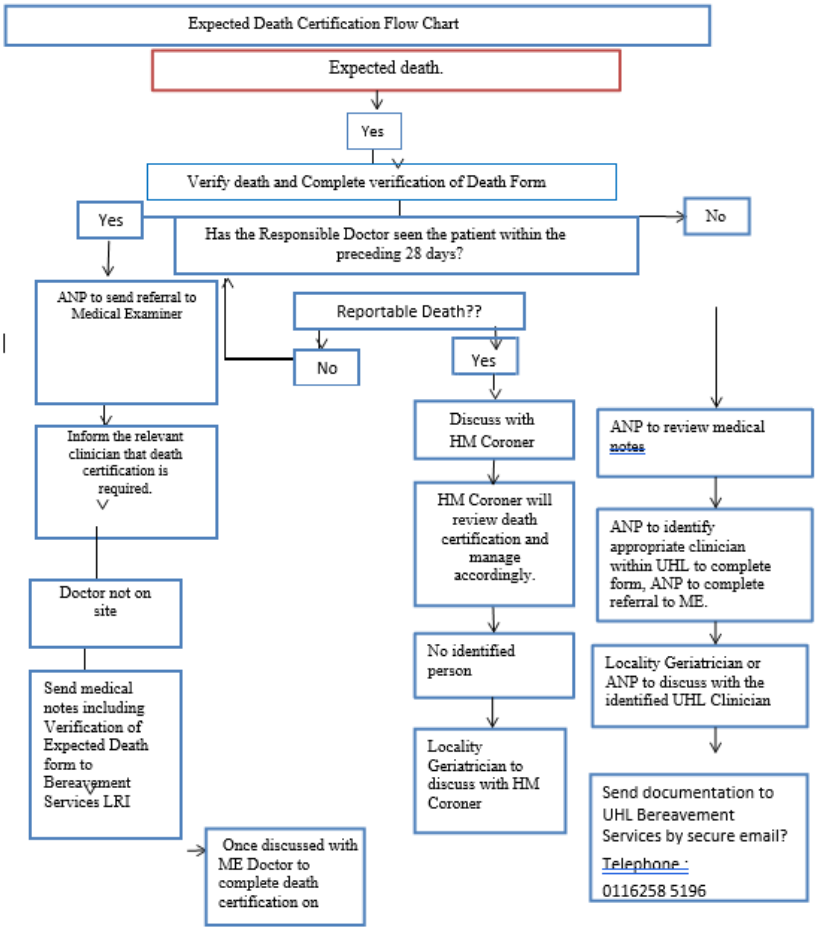
Academy of Medical Royal Colleges: A Code of Practice for the Diagnosis and Confirmation of Death 2008

10.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery, and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.
- If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Flowchart(s)



Verification of Death Record Sheet

Date…….. **Time**……

Patient's Name ……**Date of Birth**……

General Practitioner…… NHS Number……..

Date Last Seen by GP/Consultant……

Response confirmed.

1. No response to painful stimuli
2. Absence of carotid/radial pulse after palpation for 1 minute
3. Absence of heart sounds, determined by stethoscope, after minimum of 1 minute.
4. Absence of respiratory activity, determined by observation and assessment with stethoscope, after minimum of 1 minute.
5. Fixed, dilated pupils, which do not react to light Assess and confirm **all** the following criteria:

Place of Death

……

I saw this patient on …… at ……. hours and identified that death had occurred.

Time of Death ……**Time Verified**……..

VERIFIER

Print Name ……**Signature**……..

Contact Tel Number……**Position**……

Work Base……

I have authorised the removal of the body by the undertaker and made appropriate arrangements for the medical professional to be informed to discuss certification of death with the patients' family / carers.

Please retain 1 copy within the patient's records and send a copy to the General Practitioner. Inform other agencies involved with providing services for this patient.

Guidance Relating to Certification of Death within Community Hospitals

Certification of Death

Certification of death is the process of completing the 'Medical Certificate of Cause of Death' (MCCD) and currently must be completed by a medical practitioner see Appendix 2. In the event of an unexpected death refer to appendix 3.

The requirements for the completion of a MCCD are outlined in section 46B of the Burial and Cremation Act 1964. A medical certificate of cause of death (MCCD) enables the deceased's family to register the death. This provides a permanent legal record of the fact of death and enables the family to arrange disposal of the body, and to settle the deceased's estate. Information from death certificates is used to inform national statistics, so it is important to ensure the certificate is completed accurately.

General Medical Council guidance is clear that the 'responsible doctor' should complete the death certificate without delay, and must comply with the English legal requirements for reporting deaths to a coroner[i]. Section 46B does not require the doctor who attended the patient during their illness to examine the body before providing a death certificate. Although a doctor who attended the patient during the illness is not required to examine the body after death, there are other good reasons for routinely examining the body. These include: to satisfy oneself that the identity of the deceased is Confirmed, to ensure that all relevant information has been checked, and to console and support the family and answer any questions. The medical practitioner must: -

- Complete the death certificate as soon as practical and within the timeframe required by law and be ready for collection by the relatives/funeral director.
- If the medical practitioner has not seen the patient BUT the diagnosis, clinical prognosis and DNAR-CPR form for the patient has been clearly documented then a discussion between the coroner and clinician for the community hospital should occur.
- The clinician completing the death certificate is also responsible for completion of part 1 of the cremation form where applicable

Completion of a death certificate by another doctor

Section 46B (3) of the Act recognises that the 'doctor who attended the person during the illness' may be unavailable in a timely manner. It defines the circumstances under which an alternative doctor (who did not attend during the illness) can then complete a death certificate. This only relates to cases in which the death was a natural consequence of an illness. The alternative doctor should make reasonable inquiries to ensure that the attending doctor is not withholding certification because they are not satisfied as to the cause of death. The circumstances in which another doctor may sign the death certificate are:

- Where the appropriate doctor is 'unavailable'. This is defined as 'dead, unknown, missing, of unsound mind, or unable to act by virtue of a medical condition'.
- Where the doctor who attended the patient during the illness is unlikely to be able to provide a death certificate within 24 hours of the death.
- Where the doctor who attended the patient during their illness has not given a death certificate and 24 hours or more has passed since the death.
- While the Act allows this 'fall-back' option, it places more rigorous demands on the substitute certifier, who must:

a) look at the medical records made by the doctor who last attended the patient during the illness.
b) consider the circumstances of the patient's death; and
c) examine the patient's body.

Who is the responsible doctor?

When a patient dies it is the statutory duty of the doctor who has attended in the last illness to issue the MCCD. There is no clear legal definition of 'attended', but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient's medical history, investigations, and treatment. The certifying doctor should also have access to relevant medical records and the results of investigations. There is no provision under current legislation to delegate this statutory duty to any non-medical staff.

In hospital, it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, will be addressed to the consultant.

If no doctor who cared for the patient can be found, the death must be referred to the coroner to investigate and certify the cause.

If the attending doctor has not seen the patient within the 28 days preceding death, **and** has not seen the body after death either, the registrar is obliged to refer the death to the coroner before it can be registered. In these circumstances, the coroner may instruct the registrar to accept the attending doctor's MCCD for registration, despite the prolonged interval. In contrast, a doctor who has not been directly involved in the patient's care at any time during the illness from which they died cannot certify under current legislation, but he should provide the coroner with any information that may help to determine the cause of death. The coroner may then provide this information to the registrar of deaths. It will be used for mortality statistics, but the death will be legally 'uncertified' if the coroner does not investigate through an autopsy, an inquest, or both.

Deaths to refer to the coroner – Via the ME
https://coroners.leicester.gov.uk/faqs/when-a-death-is-reported/which-deaths-are-referred**/**

Deaths which involve the following should be discussed with the corners officer to determine if further action is required (see appendix 8)

- Accident
- Suicide
- Violence
- Neglect (by self or others)
- Industrial disease
- Deaths for which the cause is not known.
- Patients who have had a naso-gastric tube placed during their hospital admission.
- Surgery within last 12 months

Cremation Forms

Cremation forms can only be completed by a registered medical practitioner with a licence to practise with the General Medical Council[ii]. Two doctors are required to complete the certificates – one acting as the referee *in some areas part 1 and 2 are referred to as form 4 and 5.

Regulation 17 of the Cremation Regulations requires the medical certificate (form Cremation 4) to be completed by a registered medical practitioner with a license to practice with the General Medical Council. This includes those who hold a provisional or temporary registration with the General Medical Council.

Regulation 17 of the Cremation Regulations also provides for the confirmatory medical certificate (form Cremation 5) to be completed by a fully registered medical practitioner of at least 5 years' standing. This means a registered medical practitioner who has been fully registered under the Medical Act 1983 for at least 5 years and who has held a licence to practice for at least 5 years within the meaning of the Medical Act 1983.

There is no legal requirement that the doctor completing form 4 of the cremation form is the same doctor that has certified death, although in practice it often is the same person.

To complete the Cremation form, you should have attended the deceased during their last illness. The minimum period of hospital care sufficient to meet the requirement should normally be 24 hours. When the period is less than 24 hours you must inform a coroner.

The doctor completing Cremation form 5 must examine the body to confirm life is extinct and to check for implantable devices such as cardiac pacemakers.

We expect the medical practitioner signing form Cremation 4 to have treated the deceased during their last illness and to have seen the deceased within 14 days of death.

The form Cremation 5 medical practitioner cannot be a partner or work colleague of the form Cremation 4 medical practitioner or a relative of the deceased; the two medical practitioners must be truly independent of one another, i.e., not on the same team in hospital or a locum at the same surgery.

Equally, if the medical practitioner completing form Cremation 4 was not the deceased's usual medical practitioner or general practitioner, because the deceased died in hospital, then it is not appropriate for the deceased's GP to sign form Cremation 5. This is because it cannot be said that the deceased's GP is truly independent from the care that the deceased received during life.

Forms Cremation 4 and Cremation 5 do not need to be completed where the death has been referred to a coroner, or the application relates to the cremation of body parts, to a stillborn baby or to the exhumed remains of a deceased person who has already been buried for a period of one year or more.

Further information can be found in the Cremation (England and Wales) Regulations 2008

Completion of forms Cremation 4 (Medical Certificate) and Cremation 5 (Confirmatory Medical Certificate) (replaced forms B and C)

The most frequently occurring errors in completing these forms are: -

- Failure to complete all questions in full.
- Deletion of questions
- Incorrect completion of forms
- Illegible handwriting; and
- Discrepancies between the forms as to the date and time of death.

Abbreviations for causes of death are unacceptable where the abbreviation is unclear, unusual, or ambiguous; in such cases, the medical referee is likely to make further enquiries of you. You should sign the form with a full signature, not an abbreviation. You cannot use a stamp.

You must complete the form yourself. It must not be completed by another person on your behalf. The form Cremation 5 medical practitioner should not amend form Cremation 4 and should record any differences or discrepancies on his or her own form.

Medical referees will expect that the evidence offered on the certificates demonstrates sound clinical grounds for the cause of death given, and you should complete form Cremation 4 with this in mind.

Appendix 4 Training Requirements

Training Needs Analysis

Training topic:	Verification of Death
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development
Directorate to which the training is applicable:	☐ Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	Registered Nurses undertaking Verification of Death
Regularity of Update requirement:	One off
Who is responsible for delivery of this training?	Clinical Education Team
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)
How is this training going to be monitored?	Via uLearn/ feedback from attendees

Appendix 5 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 6 Due Regard Screening Template

Section 1	
Name of activity/proposal	Verification of Death
Date Screening commenced	June 2019
Directorate / Service carrying out the assessment	Clinical Effecrtivness Group
Name and role of person undertaking this Due Regard (Equality Analysis)	Jonathan Dexter
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of this policy is to state the standards and procedures to enable registered nurses to verify the death of a patient.	
OBJECTIVES: The objective of this policy is to ensure that patients whose death can be verified by a registered nurse is done so to enhance the continuity if end of life care for patients, their families and significant others.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	No impact expected for any protected characteristics
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	**No**
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:
Discussion at CEG and through consultation process

Signed by reviewer/assessor	Jonathan Dexter	Date	November 2023
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	S Latham	Date	November 2023

Appendix 7 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Verification and Certification of Death Policy**	
Completed by:	**Jonathan Dexter**	
Job title	**Consultant Nurse (Advanced Practice)**	**Date November 2023**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For	No	

examples, health records, criminal records or other information that people would consider to be particularly private.		
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**		
Data Privacy approval name:	**Jonathan Dexter**	
Date of approval	**November 2023**	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust