Verification of death by Registered Nurses

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1. Overview

This guideline supports and informs the process of Verification of Death by Registered Nurses who have undertaken the appropriate training. It sets out the experience and training requirements for practitioners and describes the verification of death process. It also includes details around Coroner referral and Tissue Donation.

If you have any concerns about the content of this document please contact the author or advise the Document Control Administrator.

2. Scope

2.1 The guideline applies across all Northern Care Alliance Care Organisations, hospital and community services for the verification of deaths of adults and children by registered nurses of an agreed level of experience and who have undertaken the appropriate training as set out in Section 5.2.

2.2 The following exceptions are in place;
- Neonatal Units.
- Where there is any suspicion of criminality associated with the death
- Where the death may be as a result of suicide.
- Road traffic incidents.
- A sudden and unexpected death of a child aged under 18 years of age where the Joint Agency Response procedures will be triggered (formerly “SUDC Rapid Response”)
- Any suspicious circumstances.

2.3 Religious, cultural and spiritual needs as well as any Advance Care Plans in place must be taken into consideration.

3. Background

3.1 A key element of a ‘good death’ is the timely verification and certification of death - it is an important stage in the grieving process for relatives and carers and also a key time for support (Hospice UK, 2017). In some areas through the development of locally agreed policies, nurses are trained to verify that death has taken place (RCN, 2018).

The Nursing and Midwifery Council states ‘A registered nurse may confirm or verify that death has occurred providing there is an explicit local protocol in place to allow such an action……and should include guidance on when other authorities, e.g. the police or the Coroner, should be informed prior to removal of the body. (NMC 2012)

4. What is new in this version?

4.1 This policy replaces Pennine Acute Hospitals NHS Trust EDN065 Verification of Death by Registered Nurses and Salford Royal Foundation Trust TGGC37(12) and has been updated with the following important changes;
- It has been agreed by Her Majesty’s Coroners across Greater Manchester that “Registered Nurses who have undertaken appropriate training and competencies” can
undertake the practice of verification of death, even in cases where the death is reportable to HM Coroner. Therefore, this policy now includes all deaths including child deaths with the above exceptions (Section 2.2).

- Salford and Pennine Acute guidelines merged – includes details of all relevant associated documents
- Transferred into Northern Care Alliance template
- Examination procedure for response to pain stimuli has changed – see 5.3.8

5. Guideline

5.1 The Coroner

5.1.1 Reporting to the Coroner will be necessary if;

- **It is the death of a child (under 18) unless;**
  - The child is stillborn ("any 'child' expelled or issued forth from its mother after the 24th week of pregnancy that did not breathe or show any other signs of life – including pulsation of the umbilical cord" - Royal College of Obstetricians and Gynaecologists, 2005),
  - "The child had a naturally occurring terminal illness and was being cared for on an individualised plan of care for the dying patient. In such circumstances there is not requirement to report the death to HM Coroner. It is the duty of the doctor issuing the medical certificate to ensure there is no other reason why the death must be reported."
    
    As per new guidance from the Senior Coroners of Greater Manchester.
  - No doctor attended the deceased during his or her last illness
  - Although a doctor attended during the last illness the deceased was not seen either within fourteen days before death nor after death
  - The cause of death appears to be unknown
  - The death occurred during an operation or before recovery from the effects of an anaesthetic
  - The death was due to industrial disease or poisoning
  - The death was sudden or unexpected
  - The death was unnatural or in suspicious circumstances
  - The death was due to violence or neglect
  - Please not that a referral to the Coroner is no longer required for patients who die expectedly with a Deprivation of Liberty Safeguard (DoLS) in place, unless there is any other reason for the death to be reportable.

**Please note that this is not an exhaustive list** – see below links for more information and appendix 2 for 'Amendment to the reporting of child deaths as of 1st June 2019.


Manchester Central website (NMGH);
[https://secure.manchester.gov.uk/info/626/coroners/5532/when_death_occurs/2](https://secure.manchester.gov.uk/info/626/coroners/5532/when_death_occurs/2)

5.1.2 In cases where the death is reportable to the Coroner, the nurse can verify death (excluding exceptions detailed in Section 2.2) and inform the lead clinician who should report to the Coroner and provide MCCD wherever possible.

5.1.3 See the Coroner Reporting Toolkit for further information; [http://nww.pat.nhs.uk/clinical-departments/End-of-Life-Care/Coroner%20Referral%20Toolkit%20-%20FINAL.pdf](http://nww.pat.nhs.uk/clinical-departments/End-of-Life-Care/Coroner%20Referral%20Toolkit%20-%20FINAL.pdf)

5.1.4 SRFT – medical staff complete Death Summary and Coding Form on EPR to initiate a Coroner referral.

### 5.2 Requirements for a registered nurse to verify a death

5.2.1 Registered Nurses seeking to undertake the process of verification of death must continue to operate within their own limitations and scope of practice. They should not experience any pressure to verify deaths when they are not comfortable to do so and should defer to Medical colleagues to verify deaths if they feel unsure.

5.2.2 The registered nurse must be trained and deemed competent to confirm/verify the death, and there must be an explicit local policy in place which the nurse must check for specific details. (RCN, 2018)

To verify death nurses must;

- Be a Registered Nurse at least 2 years post-registration (in some situations when a nurse is deemed appropriately trained and competent by their line manager, training could be accessed 18 months post registration).
- Have significant recent experience or training in palliative and end of life care or caring for patients and families after death.
- Have completed Verification of Expected Death Training including theory, simulation and supervised sign-off by competent practitioner with the potential exception of Senior nurses (e.g. Advanced Practitioners; Night Nurse Practitioners) joining from other Trusts, as per next point.*
- Senior nurses joining from other Trusts where Verification of Death has been a recent element of their previous role should familiarise themselves with local policy and procedure and complete the Competency Self-Assessment (Appendix 1). If they cannot answer “Yes” to all elements of the Competency Self-Assessment, it is then their own responsibility to fill any gaps in their knowledge by either attending Verification of Death training or other appropriate means.
- Have completed and signed the Competency Self-Assessment (Appendix 1)

*Staff MUST have approval from their Manager to undertake Verification of Death Training
5.3 Verification of death process - ADULT

The registered nurse undertaking the verification of death process should make every effort to inform the deceased’s Consultant/GP/treating team that death has occurred and document this in the patient’s notes.

In an acute setting, the Swan symbol should be/continue to be displayed – with consent - on the curtain/door of where the deceased is being cared for until they leave the ward/department.

Religious, cultural and spiritual needs as well as any Advance Care Plans in place must be taken into consideration.

5.3.1 Equipment required;
- Pen torch
- Stethoscope
- Gauze swab
- Watch with second hand

5.3.2 Once cardiorespiratory function has ceased and there are no signs of life (movement, swallowing, coughing), the patient should be observed by the person verifying death for a minimum of five minutes.

5.3.3 Check the absence of carotid pulse for one minute.

5.3.4 Check the absence of respiratory movement and sounds using a stethoscope, to listen to both sides of the chest, for a total of one minute.

5.3.5 Listen for heart sounds on both sides of the chest using a stethoscope for a total of one minute.

5.3.6 Check the patient’s pupil reaction with a pen torch. Pupils should be fixed, dilated and unresponsive to light. Both eyes should be checked.

5.3.7 Check the patient’s reaction to corneal reflex by using gauze to gently touch the cornea over the coloured area of the eye. No response i.e. blinking should be observed. Both eyes should be checked.

5.3.8 Using a finger and thumb, perform a trapezius squeeze. No motor response should be observed.

5.3.9 Confirm the death to persons important to the patient and offer appropriate support.
5.3.10 Document verification of death using appropriate documentation in patient’s record. If ‘Individual plan of care and support for the dying person’ is in use, ensure verification of death is completed in appropriate section.

5.3.11 Actual time of death and time of verification of death should both be clearly recorded and at least 5 minutes apart, as per Academy of Medical Royal Colleges Guidance.

5.3.12 If a parenteral infusion is in place, syringe pump/IV pump must be stopped at time of death and drugs infused and drugs yet to be infused accurately recorded.

5.3.13 Establish if the death needs reporting to a coroner – see Section 5.1.

5.3.14 If reporting to the Coroner is required;

- Leave infusion lines in place (capped and taped gently to the deceased).
- Leave endotracheal (ET) tubes in place.
- Remove medication syringe/s and syringe pump/IV pump after recording volumes infused and volume remaining.
- Leave catheters and drains in situ, spigot the tubes and apply new drainage bags after recording volumes at the time of death.
- If you wish to remove any infusion lines, drains, ET tubes etc where Coroner reporting is required, you must seek express approval from HM Coroner prior to doing so.

5.3.15 If the death does not require reporting to the coroner all lines can be removed – ensure appropriate dressings are applied to prevent leakage.

5.3.16 Offer persons important to the patient an opportunity for keepsakes, including locks of hair, sensitive photographs or hand/foot/lip prints.

5.3.17 Swan Bereavement Nurses can offer families additional support if needed. They can be contacted via the Bereavement Offices on each site:
- Salford Care Organisation: 0161 206 5175
- Oldham Care Organisation: 0161 627 8321/8322/8323
- Bury and Rochdale Care Organisation: 0161 778 3859 (Based at Fairfield General Hospital)
- North Manchester Care Organisation: 0161 720 2199
At weekends support can be accessed via Switchboard.

5.3.18 Consider Tissue donation – see Section 5.5.

5.3.19 Following verification of death, care after death must be performed according to any wishes of the deceased or persons important to them and in accordance with Care after Death Policy NCAN003(19). The deceased patient should be transferred to the mortuary/funeral directors within 4 hours whenever possible.

5.3.20 Inform patient’s medical team/primary health care team and all other relevant service providers (record date and time).
5.3.21 Every effort must be made by nursing staff to inform persons important to the patient when a patient’s condition is deteriorating or immediately following the patient’s death, if earlier contact has not been possible.

In some instances persons important to the patient may request not to be disturbed at night, any such agreement made must be documented and notification of death made at the agreed time.

The nurse should advise that, in most circumstances a doctor from the treating team will be able to issue a Medical Certificate of Cause of Death (MCCD) within 24 hours of the patient’s death, unless at weekends and bank holidays when the certificate should be made available on the next working day.

Special arrangements can be made for certain religious needs - see Faith Death procedures available on the Intranet and as Appendices in the Care after Death Policy NCAN003(19);

Pennine Acute – http://nww.pat.nhs.uk/services-departments/faith-deaths.htm
SRFT – http://intranet.srht.nhs.uk/search/?q=faith+deaths

Contact on-call chaplain for support – available via Switchboard 24/7, 365 days a year.

5.4 Verification of death process - CHILD

Registered nurses should not undertake the verification of death process in the event of a sudden and unexpected death of a child aged under 18 years of age where the Joint Agency Response procedures will be triggered (formerly “SUDC Rapid Response”).

The registered nurse undertaking the verification of death process should make every effort to inform the deceased’s Consultant/GP/treating team that death has occurred and document this in the patient’s notes.

In an acute setting, the Swan symbol should be/continue to be displayed – with consent - on the curtain/door of where the deceased is being cared for until they leave the ward/department.

Religious, cultural and spiritual needs as well as any Advance Care Plans in place must be taken into consideration.

5.4.1 Equipment required;
- Pen torch
- Stethoscope
- Gauze swab
- Watch with second hand

5.4.2 Once cardiorespiratory function has ceased and there are no signs of life (movement, swallowing, coughing) the patient should be observed by the person verifying death for a minimum of five minutes.

5.4.3 Check the absence of carotid, femoral and radial/brachial pulses for at least one minute.
(Forget Me Not Hospice, 2015)
5.4.4 Check the absence of respiratory movement and sounds using a stethoscope to listen to both sides of the chest, for a total of one minute.

5.4.5 Listen for heart sounds on both sides of the chest using a stethoscope for a total of one minute.

5.4.6 Check the patient’s pupil reaction with a pen torch. Pupils should be fixed, dilated and unresponsive to light. Both eyes should be checked.

5.4.7 Check the patient’s reaction to corneal reflex by using gauze to gently touch the cornea over the coloured area of the eye. No response i.e. blinking should be observed. Both eyes should be checked.

5.4.8 Using a finger and thumb, perform a trapezius squeeze. No motor response should be observed.

5.4.9 Forget me Not Children’s Hospice’s training acknowledges that “some guidance recommends repeating this cycle” (5.4.3-5.4.8). Whilst this is not a requirement of this policy, practitioners may wish to do so.

5.4.10 Confirm the death to persons important to the patient and offer appropriate support. Make sure that the Swan symbol is in use to ensure dignity is maintained.

5.4.11 Document verification of death using appropriate documentation in patient’s record. If ‘Individual plan of care and support for the dying person’ is in use, ensure verification of death is completed in appropriate section.

5.4.12 Actual time of death and time of verification of death should both be clearly recorded and at least 5 minutes apart, as per Academy of Medical Royal Colleges Guidance.

5.4.13 If a parenteral infusion is in place, syringe pump/IV pump must be stopped at time of death and drugs infused and drugs yet to be infused accurately recorded.

5.4.14 See section 5.1.1 for details of when the death of a child under 18 years old is exempt from reporting to HM Coroner. In cases where the death is being reported to HM Coroner;

- Leave infusion lines in place (capped and taped gently to the deceased).
- Leave endotracheal (ET) tubes in place.
- Remove medication syringe/s and syringe pump/IV pump.
- Leave catheters and drains in situ, spigot the tubes and apply new drainage bags after recording volumes at the time of death.
• If you wish to remove any infusion lines, drains, ET tubes etc in the case of a child *(under 18 years) death, you must seek express approval from HM Coroner prior to doing so.

Coroner reporting must be done by the Doctor who is also completing the MCCD. See section 5.1.

5.4.15 Offer persons important to the patient an opportunity for keepsakes, including a lock of hair, sensitive photographs or hand/foot/lip prints.

5.4.16 Swan Bereavement Nurses can offer families additional support if needed. They can be contacted via the Bereavement Offices on each site;
Salford Care Organisation: 0161 206 5175
Oldham Care Organisation: 0161 627 8321/8322/8323
Bury and Rochdale Care Organisation: 0161 778 3859 (Based at Fairfield General Hospital)
North Manchester Care Organisation: 0161 720 2199
At weekends support can be accessed via Switchboard.

At Oldham and North Manchester Care Organisations, there is a Bereavement Midwife on each Labour Ward and a Bereavement Neonatal nurse attached to the Neonatal Unit – although this guideline is not applicable for Neonates.

5.4.17 Consider Tissue donation – see Section 5.5.

5.4.18 Following verification of death, care after death must be performed according to any wishes of the deceased or persons important to them and in accordance with Care after Death Policy NCAN003(19). The deceased patient should be transferred to the mortuary/funeral directors within 4 hours.

5.4.19 Inform patient's medical team/primary health care team and all other relevant service providers (record date and time).

Every effort must be made by nursing staff to inform persons important to the child when a child’s condition is deteriorating or immediately following the child’s death, if earlier contact has not been possible.

The nurse should advise that, in most circumstances a doctor from the treating team will be able to issue a Medical Certificate of Cause of Death (MCCD) within 24 hours of the patient’s death, unless at weekends and bank holidays when the certificate should be made available on the next working day.

Special arrangements can be made for certain religious needs - see Faith Death procedures available on the Intranet and as Appendices in the Care after Death Policy NCAN003(19);

Pennine Acute – http://www.pat.nhs.uk/services-departments/faith-deaths.htm
SRFT – http://intranet.srht.nhs.uk/search/?q=faith+deaths

Contact on-call chaplain for support – available via Switchboard 24/7, 365 days a year.
5.5 Tissue Donation

5.5.1 Bury & Rochdale, North Manchester and Oldham Care Organisations

Ask family/significant other/s about consent for contact from Tissue Donation Team ("Your loved one may be eligible to be a tissue donor – would you like someone to contact you to discuss this further?") and if consent has been given;
- Inform persons important to the patient that they may not be contacted (not all patients are medically suitable for donation)
- Give information leaflet
- Refer to the Tissue Donation Team (NHS Blood and Transplant – NHSBT);
  Tissue Referral Centre - 0800 432 0559
- You will need the deceased person’s notes to hand to answer questions from the Referral Centre.

5.5.2 Salford Care Organisation

In SRFT Hospital, Tissue Donation referral is sent automatically to NHSBT on completion of Care after Death documentation on EPR.

In SRFT Community, teams caring for the deceased can refer to NHSBT Tissue Donation on the above telephone number.

Please note that if a person is to be eligible for tissue donation, they must be transferred to a mortuary/cold facility within 4 hours of the actual time of death, not time of verification of death.

6. Roles & responsibilities

All staff must work within their own Code of Professional Conduct and recognise their own limitations.

6.1 Nurses

6.1.1 Nurses trained in verification of death must complete the Competency Self-Assessment and be observed by a Doctor or Nurse who is qualified and competent to verify death the first time they complete the process.

6.1.2 Competency Self-Assessment should be completed as part of their annual contribution framework meeting, any training needs identified and actions completed (Appendix 1). If a practitioner has not undertaken the Verification of Death process since their last contribution framework meeting (12 months), they should attend the training again.

6.2 Doctors

6.2.1 Should be willing to support nursing colleagues in competency ‘sign-off’.

6.2.2 Should be willing if necessary to speak to families after death of the patient. This should be arranged at the soonest mutually convenient time.
6.2.3 The responsible doctor (or if necessary a delegated doctor) will always explain/be available to explain the cause of death they have written on the medical certificate.

6.3 Managers/Team Leaders

6.3.1 Should support staff to attend necessary training wherever possible.

6.3.2 Should monitor annual completion of self-assessment of competence at annual appraisal and recognise and support when further training is required.

7. Monitoring document effectiveness

7.1

- **Key standard:** Nurses undertaking verification of death will do so safely and effectively.
- **Methods:** Regularly available and up to date Verification of Death for Registered Nurses training; Annual Self-assessments of competence; Bereavement office data collection; Regular audit.
- **Team responsible for monitoring:** Ward Managers; District Nursing Leads; End of Life Care Teams, Bereavement teams.
- **Frequency of monitoring:** Ward Managers/DN Team Leaders at annual appraisal; audit at least annually.
- **Process for reviewing results and ensuring improvements in performance:** Audit action plans.

8. Abbreviations and definitions

- ANP – Advanced Nurse Practitioner
- DN – District Nurse
- GP – General Practitioner
- MCCD – Medical Certificate of Cause of Death
- NCA – Northern Care Alliance
- NNP – Night Nurse Practitioner

9. References

9.1 References and Associated Documents

Academy of Medical Royal Colleges (2010). A code of practice for the diagnosis and confirmation of death.


RCN (2018). Confirmation or Verification of Death by Registered Nurses.


https://www.manchestersafeguardingboards.co.uk/resource/child-deaths-advice-practitioners/

http://greatermanchesterscb.proceduresonline.com/pdfs/pr_gm_sudc.pdf
9.2 Related NCA/SRFT/PAT documents

**PAT**

- Clinical Record Keeping Policy (EDN004)
- Controlled Drugs Policy Intermediate Care. CPDI191
- Community Nurses Controlled Drugs Policy. CPDI176 (PAHT);
- TWCG12(16) Issue no. 1.1 (SRFT).
- TWCG07(15) Issue no. 1 (SRFT).
- Guidance for Staff Religious & Faith Requirements Relevant to Hospital Admissions (EDN011)
- Guidelines for Care in Last Days of Adult Life (EDC053)
- Management & Use of Medical Devices Policy. EDE019 (PAHT);
- Medicines Policy EDC018 (PAHT);
- Neonatal Death Guideline for Management (CPWC205)
- Ordering, Storage & Administration of Controlled Drugs. EDC017:
- Organ Donation & Required Referral Policy. EDC047
- Pain & Symptom Control Guidelines: Palliative Care. EDC072
- Patient Identification Policy EDN009 (PAHT);
- Standard Precautions Policy Including Hand Hygiene. CPDI086

**NCA**

- Guidelines for Care After Death NCAN003(19)
- Unified) Do Not Attempt Cardiopulmonary Resuscitation (u)DNACPR Adults over 18 Policy NCAM002(19)

**SRFT**

- Palliative Care CME T34 ‘Lock On’ Ambulatory Subcutaneous Syringe Pump Guidelines For Use In Palliative And End Of Life Care TC9(09)
- Medicines Policy 163TD(c)(33)
- Safe Management of Controlled Drugs MM23(08)
- Organ and Tissue Donation Policy TWCG10(14)
- Palliative Care Pain and Symptom Guidelines 217TD(c)50
- Patient Identification Policy TC14(06)
- Sudden Unexpected Death in Children and Young People from 0-18 years management. TW1(09)
10. Appendices

1. Competency Self-Assessment Document

2. Amendment to the reporting of child deaths as of 1st June 2019
## Verification of Death Competency Self-Assessment Document

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Forenames:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title (Mr/Mrs/Miss/Dr etc)</td>
<td></td>
</tr>
<tr>
<td>Job Title/Designation</td>
<td></td>
</tr>
<tr>
<td>Work Area/ Department</td>
<td>Phone/extension No:</td>
</tr>
</tbody>
</table>

Self-assessment of competence should be measured against the following statements: These statements are designed to indicate competence to perform this procedure. Responsibility for undertaking verification of death remains with the nurse performing the procedure, so if you are in any doubt regarding your competence to carry out verification of death, you should seek education and support to bring about improvement. Various methods including, self-directed learning, coaching and formal training may be initiated.

Carry out an initial assessment. You must be able to answer yes to all the questions before considering yourself to be competent. If you are not competent instigate learning and then repeat self-assessment.

### Questions to ask yourself: Are you competent to carry out verification of death?

#### When verifying an expected death are you able to:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Initial assessment Date</th>
<th>Second assessment Date</th>
</tr>
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<tbody>
<tr>
<td>1. Ensure all your actions adhere to NCA Verification of death by nurses procedure</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2. Ensure you have access to all relevant information before going to verify a death.</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>3. Accurately identify the deceased patient in line with local policy</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>4. Identify &amp; greet any key person (S) present to determine their preferences with regard to their role in the procedure and any cultural &amp; religious requirements</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>5. Identify and overcome any barriers to communicating with persons important to the patient.</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>6. Ensure the environment provides for the maximum possible privacy &amp; dignity for the deceased and others present throughout the procedure</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>7. Identify the equipment needed to undertake the procedure</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>8. Complete the physical examination of the patient and determine if death has occurred</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>9. Inform persons important to the patient of the death in a sensitive manner</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>10. Complete the Care after Death section in end of life care plan/EPR/patient records</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
11. Provide opportunities for persons important to the patient to ask any questions & respond appropriately | Yes/No | Yes/No
---|---|---
12. Inform them of the next steps in the process and of the range of options open to them, taking account of their preferences and any cultural or religious requirements | Yes/No | Yes/No
13. Provide and /or signpost the person’s important to the patient with supporting and appropriate information including how to obtain further information and/or support if required | Yes/No | Yes/No
14. Inform appropriate professional colleagues of the death & relevant circumstances | Yes/No | Yes/No
15. Seek advice and support when you recognise the complexity of the case is beyond your competence and capability | Yes/No | Yes/No

I require further training before I can carry out this procedure a competent manner: Yes/No

Indicate how you plan to meet your learning needs specifying dates of training where appropriate.

---

**Assessment discussed with manager**

Date:  
Signature:  
Managers Signature:  
Actions agreed
Appendix 2

AMENDMENT TO THE REPORTING OF CHILD DEATHS AS OF 1st JUNE 2019

After much deliberation and consideration the Senior Coroners for Manchester City, Manchester West and Manchester North have agreed to alter the list of reportable deaths. The amendments which will come into force from the 1st June 2019 relate to the reporting of deaths of children under the age of 18.

Please see the attached amended list of deaths which are reportable to HMCs in these areas.

As you may recall for many years all child deaths have been reportable to HMC. This provision was introduced at the time when the duty to report all child deaths to the Local Safeguarding Board was introduced. Having reflected on this HM Coroners are content to amend the list to read as follows:

If the deceased is under the age of 18 the death must be reported to HMC unless the child had a naturally occurring terminal illness and was being cared for on an end of life care plan. In such circumstances there is no requirement to report the death to HM Coroner. It is the duty of the Doctor issuing the medical certificate to ensure there is no other reason why the death must be reported.

By way of example, but not limited to these, the death must be reported if:

- The underlying condition is linked to birth trauma (or any other unnatural event)
- There is a suggestion or concern of neglect or issues relating to safeguarding
- The underlying condition is linked to any medical treatment
- The death occurred within 24 hours of admission to hospital
- Any other reason exists which makes the death a reportable death
### Document Control Information

All sections must be completed by the author prior to submission for approval

| Lead Author: | Marie Busuttil  
| Community End of Life Care Lead |

| Lead author contact details: | 0161 206 2534  
| Marie.busuttil@srf.nhs.uk |

<table>
<thead>
<tr>
<th>Consultation</th>
<th>List the persons or groups who have contributed to this policy. (please state which Care Organisation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person or group</td>
<td>Role / Department / Committee (Care Org)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Palliative Care and Bereavement Teams</td>
<td>NCA</td>
</tr>
<tr>
<td>Education Teams</td>
<td>NCA</td>
</tr>
<tr>
<td>District Nursing Service</td>
<td>SRFT</td>
</tr>
<tr>
<td>Children's Community Team</td>
<td>SRFT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endorsement</th>
<th>List the persons or groups who have seen given their support to this policy. (please state which Care Organisation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person or group</td>
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<td>---</td>
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</tr>
<tr>
<td>Clinical Effectiveness Committee</td>
<td>SRFT</td>
</tr>
<tr>
<td>Professor Matthew Makin</td>
<td>End of Life Care Committee (PaHT)</td>
</tr>
</tbody>
</table>

| Keywords / phrases: | Previous SRFT version TWCG37(12)  
| Verification, end of life care, death, confirmation, Coroner, child, SUDC, swan, donation. |

| Communication plan: | Weekly bulletin; email to Ward Managers/Matrons; email to all existing nurse verifiers; via existing Verification of Death Training.  
| Intranet message and on-going education and support |

| Document review arrangements: | This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate. |

### This section will be completed following committee approval

| Policy Approval: | Name of Approving Committee:  
| End of Life Care Committee (Pennine) Chair’s approval Matt Makin, Medical Director 23/05/19  
| Clinical Effectiveness Committee (SRFT)  
| Chairperson: Doctor Sara Barton  
| Approval date: 02.09.2019  
| Formal Committee decision (tick) | Chairperson’s approval (tick) ✓ |
12. **Equality Impact Assessment (EqIA) screening tool**

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

| 1a) Have you undertaken any consultation/involvement with service users, staff or other groups in relation to this document? | Yes | Palliative care and education team
Children’s Nursing Teams |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1b) Have any amendments been made as a result?</td>
<td>Yes</td>
<td>Many small changes</td>
</tr>
</tbody>
</table>

2) **Does this policy have the potential to affect any of the groups below differently or negatively?** This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong> (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)</td>
<td>x</td>
<td></td>
<td></td>
<td>Differences when dealing with a child death</td>
</tr>
<tr>
<td><strong>Sex</strong> (e.g. is gender neutral language used in the way the policy or information leaflet is written?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong> (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)</td>
<td>x</td>
<td></td>
<td></td>
<td>Specific information for faith deaths is available</td>
</tr>
<tr>
<td><strong>Religion &amp; Belief</strong> (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual orientation</strong> (e.g. is inclusive language used? Are there different access/prevalence rates?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy &amp; Maternity</strong> (e.g. are procedures suitable for pregnant and/or breastfeeding women?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status/civil partnership</strong> (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender Reassignment</strong> (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human Rights</strong> (e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Careers</strong> (e.g. is sufficient notice built in so can take time off work to attend appointment?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Socio/economic</strong> (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong> (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)</td>
<td>x</td>
<td></td>
<td></td>
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<td>---</td>
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<td></td>
<td></td>
<td></td>
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</tbody>
</table>

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these? We have sought advice from the equality team regarding gender category and ensuring that the information we provide will be gender neutral. We have also developed a faith document which will guide staff when dealing with patients from a diverse background to ensure that we meet their needs appropriately.

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken? Any adjustments that need to be made will be discussed with the patients and their families to ensure a reasonable adjustment plan is completed accordingly.

5) Where the policy, procedure, guidelines, patient information leaflet or project impacts on patients how have you ensured that you have met the Accessible Information Standard – please state below:
Yes – we are able to produce the documents in a preferred format as requested from patients.

EDI Team/Champion only: does the above ensure compliance with Accessible Information Standard
x Yes
o No
If no what additional mitigation is required:

Will this policy require a full impact assessment? Yes / No
Please state your rationale for the decision:
(a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on equality@pat.nhs.uk)

Author: Type/sign: Marie Busuttil Date: 31/05/2019
Sign off from Equality Champion: Naheed Nazir Date: 03/09/19