Adult Sudden and Unexpected Death Policy

Approved by: CHS Clinical Policy Group and Clinical Quality and Governance Committee

On: 23 September 11 October 2010

Review Date: September 2011

Directorate responsible for Review: CHS Nursing and Quality

Policy Number: NP113

Signature

Helen Thompson
Interim Managing Director
Community Health Services
### Equality Impact Assessment – Policy/ Service Screening Checklist

**Policy Title:** Adult Sudden and Unexpected Death Policy  
**Directorate:** Governance and Quality  
**Name of person/s auditing / authoring policy:** Eleanor Turner, Senior Nurse

**Policy/ Service Content:**

For each of the following checks is this policy sensitive to people of different age, ethnicity, gender, disability, religion or belief, sexual orientation & transgender?

- The checklists below will help you to see any strength and / or highlight improvements required to ensure that the policy / procedure is compliant with equality legislation.

#### A. Check for DIRECT or INDIRECT discrimination against any minority group of SERVICE USERS:

<table>
<thead>
<tr>
<th>Question: Does your policy/service contain any issues which may adversely impact people from using the services who otherwise meet the criteria under the grounds of:</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0</strong> Age</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.1</strong> Gender (Male, Female and Transsexual)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.2</strong> Learning Difficulties / Disability or Cognitive Impairment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.3</strong> Mental Health Need</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.4</strong> Sensory Impairment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.5</strong> Physical Disability</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.6</strong> Race or Ethnicity</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.7</strong> Religion or Belief (including other belief)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.8</strong> Sexual Orientation</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

If yes is answered to any of the above items the policy may be considered discriminatory and requires review and further work to ensure compliance with legislation.

#### B. Check for DIRECT or INDIRECT discrimination against any minority group relating to EMPLOYEES:

<table>
<thead>
<tr>
<th>Question: Does your policy/ service contain any issues which may adversely impact employees from operating under the grounds of:</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.9</strong> Age</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.0</strong> Gender (Male, Female and Transsexual)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.1</strong> Learning Difficulties / Disability or Cognitive Impairment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.2</strong> Mental Health Need</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.3</strong> Sensory Impairment</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.4</strong> Physical Disability</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>2.5</strong> Race or Ethnicity</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
If yes is answered to any of the above items the policy may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED ‘YES’ INDICATING DIRECT or INDIRECT DISCRIMINATION = 0

| Number of ‘Yes’ answers for Service users | 0 |
| Number of ‘Yes’ answers for Employees  | 0 |

<table>
<thead>
<tr>
<th>Yes/ No</th>
<th>Comments /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
</tr>
<tr>
<td>Is there a need for external or user consultation?</td>
<td>Yes The Coroner needs to see the Policy prior to ratification</td>
</tr>
<tr>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

If you have answered “Yes” to any of the above questions, it is likely the policy/ service will need a full EIA, please complete a full impact assessment. If you have identified a potential discriminatory impact of this procedural document, please refer it to policy/service administrator; together with any suggestions as to the action required to avoid/reduce adverse impact.

Signatures of authors / auditors:  Eleanor Turner, Senior Nurse
Date of signing:
# Adult Sudden and Unexpected Death Policy

<table>
<thead>
<tr>
<th>Version:</th>
<th>1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified by:</td>
<td>Clinical Quality and Governance Committee</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>11 October 2010</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Eleanor Turner</td>
</tr>
<tr>
<td>Name of responsible committee:</td>
<td>CHS Clinical Quality and Governance Committee</td>
</tr>
<tr>
<td>Date of issue for publication:</td>
<td></td>
</tr>
<tr>
<td>Review Date:</td>
<td>September 2011</td>
</tr>
<tr>
<td>Target Audience:</td>
<td></td>
</tr>
</tbody>
</table>
## CONTRIBUTION LIST

### Key individuals involved in developing the document

Original Document was developed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleanor Turner</td>
<td>Senior Nurse</td>
</tr>
<tr>
<td>Di Postle</td>
<td>Head of Nursing Primary Care</td>
</tr>
<tr>
<td>Catherine Mason</td>
<td>Coroner for Leicester City and South Leicestershire</td>
</tr>
</tbody>
</table>

Comments were received on amendments to this version (see below for list of sections updated)

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Aim</td>
<td>1</td>
</tr>
<tr>
<td>3. Scope</td>
<td>1</td>
</tr>
<tr>
<td>4. Definitions</td>
<td>2</td>
</tr>
<tr>
<td>5. Referral to Coroner</td>
<td>3</td>
</tr>
<tr>
<td>6. Roles and Responsibilities</td>
<td>3</td>
</tr>
<tr>
<td>7. Care of Sudden or Unexpected Death</td>
<td>6</td>
</tr>
<tr>
<td>8. Training</td>
<td>7</td>
</tr>
<tr>
<td>9. Staff Support</td>
<td>7</td>
</tr>
<tr>
<td>10. Audit</td>
<td>7</td>
</tr>
<tr>
<td>Pathway in the Event of Sudden Death</td>
<td>8</td>
</tr>
<tr>
<td>Pathway in the Event of Unexpected Death</td>
<td>9</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>10</td>
</tr>
<tr>
<td>Letter from Coroner for Leicester City and</td>
<td></td>
</tr>
<tr>
<td>south Leicestershire</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>12</td>
</tr>
</tbody>
</table>
Adult Sudden and Unexpected Death Policy

1. INTRODUCTION

This policy applies where the death of the individual is **beyond reasonable doubt** and where any attempt at resuscitation is deemed to be futile. **If in any doubt, commence basic life support and contact Emergency Services.** The DNA-CPR Decision Algorithm in the Resuscitation Policy may assist in supporting any decision not to commence resuscitation.

The policy and associated guidance and procedures are concerned with the process to be followed by healthcare professionals when encountering the sudden or unexpected death of an adult within the community. In the event of the death of a child, staff should refer to the guidance available on the Local Children Safeguarding Board website, www.lscb-llr.org.

2. AIM

The aim of this policy is to outline the process that staff are required to follow in the event of a sudden or unexpected death and to ensure the quality of care provision to the deceased and bereaved by promoting a consistent approach across Community Health Services.

3. SCOPE

3.1 This policy is applicable to all health care professionals including contracted medical staff, who have a responsibility and accountability for providing care to patients within the community setting and community hospitals, within Community Health Services.

Health care professionals have a responsibility to work within their own professional codes of conduct.

3.2 All nursing staff should ensure that they attend:

- Basic Life Support update sessions every year
- Equality and Diversity training sessions at least every 3 years
- Advanced Life Support Update session every year, if specified for role

Nursing staff should ensure that they adhere to:

- NMC Record Keeping (2009)

The following policies should be adhered to with this policy:

- Verification of Adult Expected Death (2010)
- Resuscitation Policy (Revised 2010)
• All relevant Infection Control Policies

3.3 It is the responsibility of all managers to include awareness of this policy at induction, during PDR reviews, when applicable to KSF outlines, and at team meetings when launched or updated.

National Guidance
Help is at Hand, Department of Health (2010) publication.

4. DEFINITIONS

There are no nationally agreed definitions, however, for the purposes of this policy the following apply:

i Expected Death
A death where the patient was expected to die or their friends or family had been informed was terminally ill or likely to die. These are usually determined by the fact that the patient’s own GP will be able to complete a certification of death and the patient often has a DNA-CPR form signed in anticipation of the event.

ii Sudden Death
Any violent or unnatural death, a death of which the cause is unknown or unanticipated including those that occur in unexplained or suspicious circumstances.

iii Unexpected Death
A death which is not anticipated as a result of the person’s current condition. This may include the death of a person with a terminal illness, where that person’s death was not imminently expected as a consequence of their illness.

It is recognised that some patients may die as a result of age or fragility consequent to suffering various co-morbidities. Whilst their death might not have been imminently expected, it is nonetheless a natural consequence of their age and general condition. In these circumstances, staff caring for such patients should endeavour to anticipate the possibility of their death and ensure that appropriate discussions have been held between the patient, where appropriate, their family/carers and medical and nursing staff involved in their care. A medical management plan which considers the extent of medical intervention in the event of a deterioration in their condition should be in place, and a decision should, wherever possible, have been made concerning the appropriateness of resuscitation in the event of cardiac or respiratory arrest. This will ensure that the patient can experience a dignified death without inappropriate and potentially distressing interventions taking place.
5. REFERRAL TO CORONER

If a death meets the following criteria the Coroner should be informed. (Ref:3)

1) Cause unknown
2) Cannot readily be certified as being due to natural causes
3) The deceased was not attended by the GP during their last illness or
   was not seen in the last 14 days by the GP
4) Has not been viewed after death by the G.P
5) There are any suspicious circumstances
6) The death may be linked to an accident whenever it occurred (no time
   limit)
7) Self neglect or neglect by others
8) Death occurred or illness has arisen during or shortly after detention in
   police or prison custody
9) The deceased was detained under the Mental Health Act (including
   hospitals)
10) Death linked to an abortion
11) The death might have been contributed to by the actions of the
    deceased themselves such as a history of drug or solvent abuse / self
    injury or over dose
12) The death could be due to industrial disease or related in anyway to the
    deceased’s employment
13) The death occurred during an operation or before full recovery from the
    effects of an anaesthetic or was in anyway related to anaesthetic. In
    any event death within 24 hours should be reported.
14) The death may be related to a medical procedure or treatment whether
    invasive or not
15) The death may be due to lack of medical care
16) There are any other unusual or disturbing features to the case
17) The death occurred within 24 hours of admission to hospital UNLESS
    the admission was purely for terminal care
18) It may be wise to report any deaths where there is an allegation of
    medical mismanagement.

IF IN DOUBT CONTACT CORONER’S OFFICE FOR FURTHER ADVICE
AND DIRECTION

6. ROLES AND RESPONSIBILITIES

In the event of a sudden/suspicious death:

a) Try not to disturb the scene, ie don’t touch, move or disturb anything.

b) Do not remove any parenteral drug administration equipment or any life-
   prolonging equipment prior to the police attending the scene.

c) If no doctor on site, contact emergency services, who will confirm death
   and contact the police if deemed necessary.
d) If GP on site and confirms death, the police should then be informed.

6.1 Director/On-call Director

6.1.1 The Director/on-call Director is responsible for acting upon information provided on a suspicious death and for providing support to the on-call manager.

6.1.2 The director/on-call director is responsible for managing potential media interest in the sudden or unexpected death.

6.2 On-call Manager

6.2.1 The ITM hospital on-call manager is responsible for providing support to the clinical area where staff may be distressed by the sudden or unexpected death of a patient.

6.2.2 The ITM hospital/on-call manager is responsible for giving clear instruction and direction to staff in the management of a suspicious death that requires police/coronor investigation and for liaising with the on-call director.

6.2.3 The ITM hospital/on-call manager is responsible for acting on any concerns expressed by staff.

6.2.4 The ITM hospital/on-call manager is responsible for liaising with the police and commencing the collection of statements.

6.2.5 The ITM hospital/on-call manager is responsible for liaising with the patient’s family/next of kin.

6.3 Line Managers

6.3.1 The line manager is responsible for providing support and acting on staff concerns 'in hours'.

6.3.2 Escalate to the ITM and, as appropriate, to the Locality Service Manager/Head of Service. They will determine whether the serious incidents process needs to be followed. If out of hours, contact needs to be via the director on-call.

6.3.3 Inform the Head of Provider Services who will inform the communications lead.

6.3.4 Inform the service manager for your area.

6.3.5 Ensure the police have been contacted in the event of a sudden/suspicious death.
6.3.6 Liaise with the police and with the Coroner’s Office in cases of sudden death.

6.3.7 Inform the Health and Safety Manager – if any related risk issues.

6.3.8 After discussion with the emergency services, agree most sensitive way of informing the next of kin.

6.3.9 Collect and secure the completed patient record the same working day.

6.4 Nurse in Charge

In the event of a sudden or unexpected death, the nurse in charge must also:

6.4.1 Escalate to the ITM and, as appropriate, to the Locality Service Manager / Head of Service. They will determine whether the serious incidents process needs to be followed. If out of hours, contact need to be via the manager/director on call.

6.4.2 Inform the Head of Provider Services who will inform the communications lead.

6.4.3 Inform the Service Manager for your area.

6.4.4 Liaise with the police and with the Coroner’s Office in cases of sudden/suspicious death.

6.4.5 Inform the Health and Safety Manager if any related risk issues

6.4.6 If GP is on site, they may confirm death. The Coroner’s Office will then need to be informed.

6.4.7 If GP is not on site, the Out of Hours service should be contacted to arrange for a doctor to attend to confirm death.

6.4.8 Agree with Manager most sensitive way of informing the next of kin.

6.4.9 Collect and secure the completed patient record the same working day.

6.4.10 Complete an incident report form, following LCRCHS untoward incidents procedure (NQ007).
7. **CARE OF SUDDEN OR UNEXPECTED DEATH**

7.1 Nurse verification **MUST NOT** be carried out if the death is “unexpected”.

7.2 If the death is ‘sudden’, the scene should not be disturbed and the police should be contacted immediately.

7.3 In the case of ‘unexpected’ death, the contracted GP or on-call medical officer should be informed of the patient’s death, it’s manner and any circumstances which may provide additional information. The patient’s own G.P should also be informed of their patient’s death.

7.4 Even if a Do Not Attempt Cardio-Pulmonary Resuscitation form is in place, the death may still be deemed ‘unexpected’ (see Definitions and criteria in section 5) In this instance the contracted GP or on-call medical officer should be contacted to request confirmation of the death.

7.5 In cases where patients wish to receive active resuscitation, all deaths in this category should be confirmed by the contracted GP or on-call medical officer and **MAY NOT** be verified by nursing staff.

7.6 All deaths should be considered “unexpected” unless it is otherwise clearly documented in the patient’s medical notes that death is expected.

7.7 It is the responsibility of the contracted GP or on-call medical officer to inform the Coroner in all cases of sudden or unexpected death. However, it is the nurse’s responsibility to inform the on-call manager if they are concerned that medical actions do not appear appropriate to the manner of death.

7.8 Where EMAS have attended a patient’s resuscitation, they should also be involved in the decision to contact the police should this be deemed necessary, ie if there are felt to be any suspicious circumstances surrounding the death.

7.9 If the request for a doctor to verify is refused or nurses are given verbal permission to verify, the Senior Nurse on duty should contact the Hospital Manager (work hours) or the on-call manager (out-of-hours) for advice and direction.

7.10 It is the on – call manager’s responsibility when contacted to:
- ascertain reasons for concern
- apply manner / mode of death to referral criteria for Coroner
- telephone the Coroner for advice unless there are suspicious circumstances, in which case they should inform the police

**Contact:**  **Leicestershire Constabulary on 0116 2222222**

During office hours the Coroner may be contacted on: **01509 268748**
7.11 If manner of death is deemed unexpected or suspicious and requires the intervention of the Coroner / police, the on-call manager should contact the on-call director for the Community Health Services.

7.12 If a death appears to have occurred under suspicious circumstances:

- DO NOT TOUCH OR MOVE THE BODY.
- inform the on-call manager who should inform the police
- notify G.P
- complete statements

7.13 Where a post-mortem examination is to be requested please refer to the Department of Health Code for Families & Post Mortems for further guidance.

7.14 Once death has been verified, the body may be removed to the Coroner’s funeral home or to a funeral home nominated by the patient’s next of kin / family. If the body is transferred to a funeral home designated by the family, the funeral director of that home should be informed that the death is being referred to the Coroner’s office and that they should not touch the body until they have been contacted by the Coroner.

8. TRAINING

Service managers should link KSF outlines and staff responsibilities to any identified learning opportunities at individual PDR’s and service training plans in order to fulfil the expectations of this policy.

9. STAFF SUPPORT

Arrangements for staff support following a sudden death incident will be made by the line manager and via Occupational Health if necessary.

10. AUDIT

Compliance with this policy will be monitored through review of incident forms and monitoring of Serious Untoward Incidents.
**Pathway in the event of a sudden death**
Risk assess the situation to maintain health and safety

---

### Member of staff responding to a sudden death

Only applies where the death of an individual is beyond reasonable doubt

---

If in any doubt, commence basic life support and call Emergency Services

---

### Sudden/suspicious death

In either patient’s own home or on CHS premises – do not disturb the scene

---

Contact the police

---

If staff arrive at someone’s home, cannot gain access but can see the individual, the police must be contacted

---

- Wait for police to arrive and co-operate with their instructions
- Death will need to be confirmed by a medical practitioner – a nurse must not verify death in cases of unexpected or sudden death
- No health professional should remove any equipment from a deceased patient until death has been confirmed by a medical practitioner and consent has been given by the police. The environment should be disturbed as little as possible
- Inform your line manager
- Complete incident form before the end of the working shift
- Make thorough notes in health care records
- Inform GP
Pathway in the Event of an Unexpected Death
Risk assess the situation to maintain health and safety

Member of staff responding to an unexpected death
Only applies where the death of an individual is beyond reasonable doubt

If in any doubt, commence basic life support and contact Emergency Services

Unexpected death
In either patient’s home or on CHS premises

Request medical practitioner to confirm death – either GP or on-call medical practitioner
Nurses may not verify death in cases of unexpected death

- Await confirmation of death by medical practitioner
- Ensure Coroner’s office informed
- No health professional should remove any equipment from a dead patient until Coroner’s permission obtained
- Agree arrangements for informing next of kin
- Inform your line manager
- Complete incident form before the end of working shift
- Make thorough notes in health care records
- Inform patient’s own GP if he/she has not attended
- Secure patient’s health care records before the end of working shift
Appendix 1

Mrs. Catherine Mason
Coroner for Leicester City and South Leicestershire
Telephone: 0116 225 2534/2535
and
Mr. Trevor Kirkman
Coroner for Rutland and North Leicestershire
Telephone: 01509 268748

To: all NHS Trusts, General Practitioners Surgeries and Undertakers within Leicester, Leicestershire & Rutland

Dear Colleagues,

As Her Majesty’s Coroners for Leicester, Leicestershire and Rutland, we are writing to you, to advise you of changes we are making in the way we deal with all sudden deaths.

Presently, all sudden deaths within Leicester, Leicestershire and Rutland are dealt with by officers of the Leicestershire Constabulary, acting on our behalf. This process is now somewhat outdated and it must be recognised that police officer time is a valuable resource. The sudden death of a loved one is a stressful experience for relatives and family members. Police attendance can be seen as intrusive and troublesome, often delaying the process of Coroners removal of the deceased to a suitable place of rest.

It is our decision therefore, that in agreement with Leicestershire Constabulary and the East Midlands Ambulance Service NHS Trust, that as of 00.00hrs on Saturday 1st August 2009, all sudden and unexpected deaths will be attended to by the East Midlands Ambulance Service. The EMAS staff will, as they do now, certify death and forward the necessary documentation to our Coroners officers. Leicestershire Constabulary officers will not attend the death unless the EMAS staff consider the circumstances to be suspicious.

There are a number of situations where the police will still attend sudden and unexpected deaths and these are as listed below:-

1) Where the circumstances are suspicious or cannot be explained;
2) If the deceased is under 18 years of age;
3) Where death did not occur in the home of the deceased or relative of the deceased (home includes residential home and gardens / yards etc);
4) If there is no known General Practitioner (GP) for the deceased;
5) Where a relative/other responsible person is not easily contactable;
6) If there are obvious physical signs of trauma or apparent deliberate violence;
7) Where there is an insecurity at the premises or signs of forced entry;
8) Deaths which may result in criminal charges;
9) Deaths caused as a result of industrial or agricultural accidents and work-related deaths;
10) Suicides;
11) Drug related deaths and suspicions of such;
12) Deaths as a result of drowning including diving deaths;
13) Deaths in police or prison custody whilst serving a custodial sentence or if lawfully detained in any institution;
14) Deaths on the Railway (responsibility of British Transport Police);
15) Deaths at MOD Establishments;
16) Deaths as a result of fires;
17) Fatal Road Traffic Collisions;
18) Where a G.P. certifies death, without EMAS attendance.

I hope that you will understand that this new process of dealing with these type of deaths will have many benefits. Families of the deceased should experience a faster process of the death being attended to and dealt with. There will be no police involvement and the opportunity for the perceived stigma of police officers being at the scene of a death will be diminished.

Finally, police officers will be able to redirect their efforts to other equally important work within their communities.

This process has long since been adopted by our colleagues in the neighbouring counties of Nottinghamshire and Derbyshire and they have found that it works well.

We would be grateful if you could advise all of your colleagues and staff of these changes.

Yours Faithfully,

Signed
Mrs Catherine Mason
Her Majesty’s Coroner
Coroner for Leicester City and South Leicestershire
Room 6
Town Hall
Leicester
LE1-9BG.

Signed
Mr Trevor Kirkman
Her Majesty’s Coroner
Coroner for Rutland and North Leicestershire
34 Woodgate
Loughborough
Leicestershire
LE11-2TY
REFERENCES

1. Policy for the Care of a Deceased Patient in the Community Hospital 2008
   Leicestershire County and Rutland Primary Care Trust

2. Coroners and Justice Act 2009


4. Royal College of Nursing - Registered Nurse Confirmation (Verification) of
   Death

5. Coroners’ letter August 2009