Care of the Deceased Policy

This document sets out Leicestershire Partnership Trusts Policy for the care of a patient who has died (deceased patient) from the point after verification and confirmation of death until transfer to a Funeral Director or Mortuary.

Key words: Deceased

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Approved by: End of Life Care group, Quality Forum

Ratified By: Quality Forum

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Type of Policy: clinical and non-clinical / sensitive.

Contents

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SUMMARY & AIM

This policy describes the roles and responsibilities of LPT staff in ensuring patients who die under the care of the Trust, regardless of the death being expected, unexpected, natural, or unnatural are treated with dignity and respect until their care is handed to a funeral director or mortuary, and that timely after death administrative processes occur.

There are two key process maps one for care of the deceased in an in-patient setting- page 9 and care of the deceased in a community setting page 10.

KEY REQUIREMENTS

Caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right and it is not at all easy to coordinate everything that needs to happen.

This policy and guidance will help to ensure staff can provide professional and compassionate high standards of care following a patient's death. Ensuring dignity and respect and enabling effective communication with families and other agencies at an emotional time from the point of death (after verification – please see separate Trust policy) until transfer to a Funeral Service Director or Mortuary.

We also recognise that we, as care givers and our colleagues who are involved in the care process, may also be affected at this emotional and stressful time.

TARGET AUDIENCE:

Medical staff, Registered Nurses, Senior Managers, Directors, Nursing Associates, Healthcare Support Nurses, Ward Clerks, Chaplaincy, Bereavement support Nurse, Clinical Education team.

TRAINING

No training required specific to the policy

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
16	4/10/2024	Updated in line with new guidance for: - Medical Examiner (ME) processes, to include: revised Notification of Death form & bereavement checklist; ME and Bereavement Support process map; Care of the Deceased process maps. - Infection prevention guidance. - Cultural and Religious guidance - Hospital funerals - Child death process - Bereavement support - Tissue donation
17-19	November 2024 - January 2025	Working Draft for consultation process.

For Further Information Contact: **End of Life Care Group**

1.2 Key individuals involved in developing and consulting on the document

Michelle Churchard Smith, Deputy Director of Nursing and Quality

Emma Wallis, Deputy Director of Nursing and Quality

Kim Sanger, Bereavement Support Nurse

Professor Peter Furness, Lead Medical Examiner

LLR Senior Coroners & Leicestershire Police

Kartar Bring, Head of Chaplaincy

Ged Swinton, Senior Resuscitation Officer

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LPT End of Life Care group members

Michelle Law, Integrated Community Specialist Palliative Care Matron

Katie Fenwick, Senior Nurse, Diana Team

Julie Potts, Palliative Care Lead, Diana Team

Jacqui Newton, Deputy Head of Nursing, Community Mental Heath

Heads of Nursing

LLR Designated Doctor for Child Deaths

Trust Policy experts

1.3 Governance

Level 2 or 3 approving delivery group – End of Life Care Group / Quality Forum

Level 1 Committee to ratify policy – Quality and Safety Committee

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 (Amendment) Regulations 2023 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.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

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 3) of this policy

1.6 Definitions that apply to this policy.

Expected Death	Death is “expected” when reasonably foreseen as likely for example, the patient has a completed individualised End of Life (EoL) care plan, or it has been documented in the patient’s records by a senior clinician that death is expected for Last Days of Life. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form / Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in place
Unexpected Death	A death not reasonably foreseen as likely, There is no ReSPECT form / DNACPR in place.

Natural Death	Death occurs as a result of the aging process or progression of a natural illness/disease.
Un-natural Death	Death not considered to be entirely due to natural causes (not ageing or natural illness /disease progression). Examples: accidents (fall, choking), incidents (medication error), suicides.
Last Offices/Care after death	The procedures performed for a person shortly after death to prepare their body for transfer to the care of funeral directors' or mortuary.
Verification of Death	Sometimes referred to as pronouncing death or confirming death this is the procedure of determining whether a person is deceased undertaken by appropriately trained clinicians.
Certification of Death	The process of completing a Medical Certificate of Cause of Death (MCCD) and can only be carried out by a medical practitioner. This certificate details the cause of death and enables the deceased's family to register the death and make funeral arrangements.
Code of Practice Mental Health Act 1983	This Code of Practice provides statutory guidance to registered medical practitioners, approved clinicians, managers, and staff of providers, and approved mental health professionals on how they should carry out functions under the Mental Health Act ('the Act') in practice. It is statutory guidance for registered medical practitioners and other professionals in relation to the medical treatment of patients suffering from mental disorder.
Detained	Being detained under the Mental Health Act (also known as being sectioned) means that a person is detained in hospital for assessment or treatment or in the community if the patient is on a Community Treatment Order.
DoLs	The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive a patient who lacks capacity to consent to their care and treatment of their liberty in order to keep them safe from harm.
Learning from deaths	A framework to help standardise and improve how NHS providers identify, report, investigate and learn from deaths.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0 Purpose and Introduction

Caring for a person at the end of their life, and after death, is enormously important and a privilege. There is only one chance to get it right and it is not at all easy to coordinate everything that needs to happen.

This policy and guidance is intended to ensure staff can provide professional and compassionate high standards of care following a patient's death. Ensuring dignity and respect and enabling effective communication with families and other agencies at an emotional time from the point of death (after verification – please see separate Trust policy) until transfer their care to a Funeral Service Director or Mortuary.

We also recognise that we, as care givers and our colleagues who are involved in the care process, may also be affected at this emotional and stressful time.

This policy should be used in conjunction with the appendices and references.

2.1 Summary and Key Points

This policy describes the roles and responsibilities of LPT staff in ensuring patients who die in the care of the Trust, regardless of the death being expected, unexpected, natural or unnatural are treated with dignity and respect until transfer to a funeral director or mortuary, and that timely after death administrative processes occur.

3 Policy Requirements

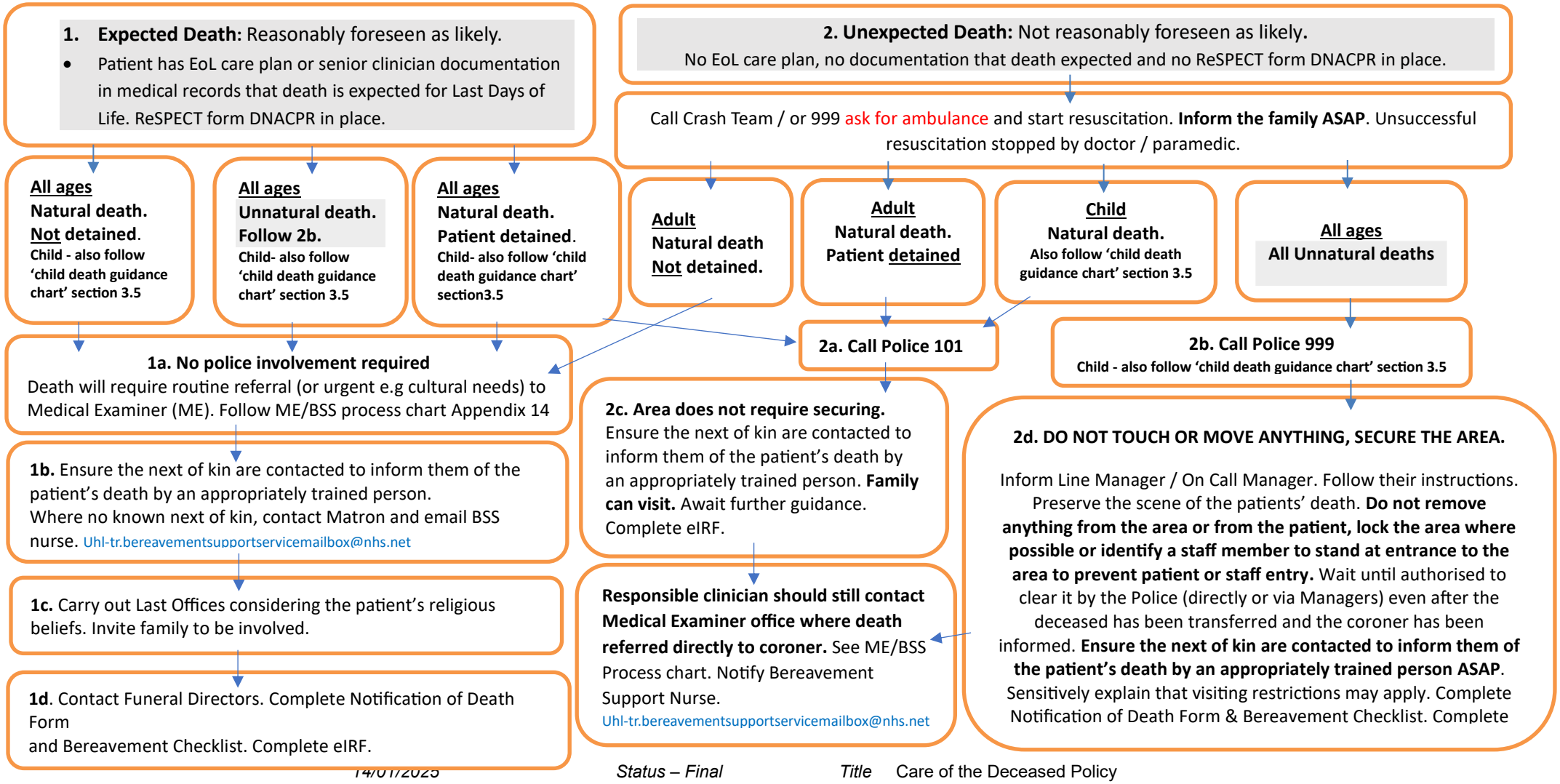
3.1 Leicestershire Partnership Trust (referred to thereafter in this document as 'the Trust') is committed to ensuring that all clinical staff can provide high standards of care following a patient's death, ensuring dignity and respect, and communicating effectively with families and other agencies at an emotional time.

3.2 This policy provides guidance and procedures to be followed when patients die whilst in the Trusts direct care either in inpatient or community settings. It is recognised that the Trust provides care and treatment in a variety of settings. In an LPT inpatient setting, responsibility for providing care to the deceased lies with the Trust.

3.3 In Community settings staff from the Trust may be involved in supporting and assisting family members or carers with the care of the deceased in their own homes but are not responsible for the coordination of events thereafter.

3.4a Care of Deceased Process Map. LPT In- Patient areas (V3)

Natural death: death occurs as a result of the aging process or progression of a natural illness/disease.
Decision making is based on HONEST HELD BELIEF - If ANY suspicion a third party has caused or contributed to the death by act or omission, treat as un-natural.
Un-natural death: death not considered to be entirely due to natural causes (not ageing or natural illness /disease progression). Examples: accidents (fall, choking), incidents (medication error), suicides.
Detained: held under a statutory power (e.g. Mental Health Act 1983). **Not detained (informal)**: not held under a statutory power (no state imposition upon freedoms).



3.4b Care of Deceased Process Map. LPT Community deaths.

Natural death: death occurs as a result of the aging process or progression of a natural illness/disease.
Decision making is based on HONEST HELD BELIEF - If ANY suspicion to suspect a third party has caused or contributed to the death by act or omission, treat as un-natural.
Un-natural death: death not considered to be entirely due to natural causes (not ageing or natural illness /disease progression). Examples: accidents (fall, choking), incidents (medication error), suicides.

1. Expected Death: Reasonably foreseen as likely.

- Patient has EoL care plan or senior clinician documentation in medical records that death is expected for Last Days of Life.
- ReSPECT form DNACPR in place.

All ages
Natural death.
Child - also follow 'child death guidance chart' section 3.5

All ages
Unnatural death. Follow 2a.
Child- also follow 'child death guidance chart' section 3.5

1a. Where not present, ensure the next of kin are contacted ASAP to inform them of the patient's death by an appropriately trained person. Where no known next of kin, contact community service team leader.

1b. No police involvement required
After death verified (as per verification of death policy), death will require routine referral (or urgent e.g cultural needs) to Medical Examiner by GP.
DMH Only – Complete eIRF for expected death too

1c. Offer assistance and **s**upport family as required to **c**arry out Last Offices considering the patient's religious beliefs.

1d. Offer verbal information regarding contacting a funeral director, what happens next and relevant service specific bereavement booklets.
Notify GP.

2. Unexpected Death: Not reasonably foreseen as likely**.**
No EoL care plan, no documentation that death expected and no known ReSPECT form DNACPR in place.

2a Call 999 East Midland Ambulance Service (EMAS) and start resuscitation as advised.
Where EMAS advise NOT to commence resuscitation (where evident patient has died)
EMAS will direct next steps and who to contact dependant on individual circumstances.
Inform the family ASAP if not present.
Unsuccessful resuscitation stopped by doctor / paramedic.

Child Death - also follow 'child death guidance chart' section 3.5

2b. if suspected unnatural and police being informed by EMAS, DO NOT TOUCH OR MOVE ANYTHING, SECURE THE AREA.

Inform Line Manager / On Call Manager. Follow their instructions.
Preserve the scene of the patients' death. **Do not remove anything from the area or from the patient, secure the area where possible.** Wait until authorised to clear it by the Police.
Ensure the next of kin are contacted to inform them of the patient's death by an appropriately trained person ASAP. Complete eIRF.

2c. If EMAS feel Police involvement is needed, they will contact them. Where Police involvement is not needed, EMAS will contact the GP.

3.5 LLR – Child Death guidance charts:

Leicester, Leicestershire & Rutland Joint Agency Response following the death of a child.
(Liveborn of any gestation up to 17 years 364 days).

Joint Agency Response criteria:

- Death in suspicious circumstances.
- Death due to external causes.
- Death which is sudden (not anticipated 24 hours prior) and for which there is no immediately apparent medical explanation (i.e. unable to issue MCCD).
- Death whilst detained under the Mental Health Act or whilst in custody.
- Medically unattended stillbirth.
- Collapse from any of the above with poor prognosis and not expected to survive – JAR to be initiated at point of collapse.

Child declared deceased in Emergency Department (ED).

Child declared deceased on scene - conveyed to Emergency Department (ED). *Direct conveyance to mortuary only in exceptional circumstances following liaison between Police & ED Consultant.*

- Attending doctor to contact on-call Detective Inspector for Child Deaths to initiate the Joint Agency Response.
- Coroner to be notified of the death.
- Multiagency liaison with Childrens Social Care (consideration of need for section 47 strategy meeting).

Within 24 hours/next working day: LLR CDOP to be notified of the death via eCDOP: www.ecdop.co.uk/llr/public

Within 24 hours/next working day from receipt of notification:

- LLR CDOP notify all relevant professionals of the death.
- **Child Death Initial Meeting** held – multiagency meeting to share information, identify actions & coordinate support for family.

Within 48 hours: Joint Home Visit by Police & Child Death Review Nurse

Within 10 days: LLR CDOP request for Reporting Forms sent to all relevant professionals via eCDOP.

Coroner's post-mortem examination, ancillary investigations & governance reviews by all relevant agencies involved, completion of CDOP Reporting Forms. Ongoing support for family.

Once all investigations & information gathering complete:

- **Child Death Review Meeting** held - multiagency meeting to review information, analyse contributory factors, identify any actions needed, including feedback from family.
- Report of CDR Meeting to HM Coroner

Coroner's Inquest

Once inquest completed:

- **Child Death Overview Panel** – multiagency review of anonymised case to identify contributory and modifiable factors and identify any local/regional/national actions to take to reduce risk of future child deaths.

Leicester, Leicestershire & Rutland response following the expected death of a child outside of the Neonatal Unit/Delivery Suite (liveborn of any gestation up to 17 years 364 days).

Child declared deceased having been in receipt of end-of-life care, or as a result of a recognised medical condition (not meeting criteria for Joint Agency Response).

Practitioners involved to follow usual agency Standard Operating Procedures for care of the deceased and support for the bereaved.

Attending doctor to discuss with Medical Examiner and complete Medical Certificate of Cause of Death (MCCD).

Within 24 hours/next working day: LLR CDOP to be notified of the death via eCDOP: www.ecdop.co.uk/llr/public

Within 24 hours/next working day from receipt of notification:

- LLR CDOP notify all relevant professionals of the death.
- **Child Death Initial Meeting** held – multiagency meeting to share information, identify actions & coordinate support for family.

Information to be shared with the family about the Child Death Review Process, and supported to engage with the process if they wish to.

Within 10 days: LLR CDOP request for Reporting Forms sent to all relevant professionals via eCDOP.

Any ancillary investigations (including hospital post-mortem examination) & governance reviews by all relevant agencies involved, completion of CDOP Reporting Forms. Ongoing support for family.

Once all investigations & information gathering complete:

- **Child Death Review Meeting** held - multiagency meeting to review information, analyse contributory factors, identify any actions needed, including feedback from family.

Once CDR Meeting completed:

- **Child Death Overview Panel** – multiagency review of anonymised case to identify contributory and modifiable factors and identify any local/regional/national actions to take to reduce risk of future child deaths.

4.0 Duties within the Organisation

4.1 Policy, Guideline or Procedure / Protocol Author:

Michelle Churchard Smith, Kim Sanger and Emma Wallis

4.2 Lead Director: Medical Director and Executive Director of Nursing, AHPs and Quality

Directors, Heads of Service are responsible for:

- Ensuring all clinical staff are aware of the policy and attend any training identified
- Ensuring they are aware of the policy and requirement to support clinical staff when they receive a report of a death, within work time or while on call.

4.3 Senior Managers, Matrons and Team Leads are responsible for:

- Ensuring all clinical staff are aware of the policy and attend any training identified during the appraisal process as part of their individual development plan .
- Ensuring they are aware of the policy and updates and requirement to support clinical staff
- when they receive a report of a patient death
- Coordination of communication and activity between family members and the funeral directors/ mortuary and in unexpected deaths the police/ Coroner's Office.

4.4 Responsibility of Clinical Staff

- If the death is unexpected or unnatural it is the duty of all staff to assist in a Coroner's investigation as requested. The Police will be acting as the Coroner's Officers to conduct such an investigation.
- If the deceased is under 18 years of age, it is the duty of all staff to follow statutory guidance as set out in Working Together to Safeguard Children 2023 in relation to child deaths, and to ensure the Child Death Review team are of that death.

4.5 In-patient Medical Staff are responsible for:

- Declaring and documenting that life is extinct, referral to the Medical Examiner and referral to
  the HM Coroner as required.
- Completion of the appropriate Medical Certificate for Cause of Death for non- Coroner cases.
  Please refer to the Verification of Death Policy for guidance.

- In conjunction with nursing staff, informing other patients of the patients' death and ensuring they have access to ongoing support.
- In conjunction with nursing staff, informing family of the patients' death and ensuring all appropriate documentation is completed.
- In conjunction with nursing staff, informing the MHA Office, Local Authority if under a DoLs, Child Death Review team, and CQC via the online notifications process as applicable.

4.6 Registered Nurses are responsible for:

- Verifying death and if appropriately trained declaring the patient has died, ***Please refer to the Verification of Death Policy for guidance.***
- Notifying the relevant Manager, On Call Manager, Doctor / ANP (Advanced Nurse Practitioner) and Bed Manager (where applicable) of the patients' death and circumstances.
- For non-coroners cases ensuring certification of death takes place. ***Please refer to the Verification of Death Policy for guidance.***
- Offering the bereaved the opportunity to discuss the possible option of tissue donation with the Tissue Donation Services and make referral where appropriate. (See bereavement check list Appendix 13).
- Preparing the deceased patient for family visiting or transfer to a funeral director or mortuary (In-patients only).
- Completion of the Notification of Death Form and bereavement check list (Appendix 13) (In-patients only)
- Ensuring relevant Infection Prevention and Control procedures are adhered to (Appendix 11 and relevant IPC policies) and where there are infection prevention and control, or other risks relevant staff and funeral directors are informed.
- Arranging transfer to the funeral directors and recording the date and time of release by the ward (In-patient only).
- In conjunction with medical staff informing family of the patients' death, offering bereavement support and ensuring all appropriate documentation is completed.
- **(In-patient only)** Informing the Bereavement Support Nurse, team leader and Matron where there is no family to ensure appropriate arrangements are made (Appendix 12).
- Ensuring all equipment is appropriately cleaned after the deceased patient has left the area.
- In conjunction with medical staff where required informing the Mental Health Act (MHA) Office, Local Authority (DoLs) and CQC.
- The management of the deceased patients' property in conjunction with the Ward Clerk / Service Administrator. ***Please refer to patients' property policy.*** (In-patients only).

4.7 Bereavement Support Nurse (In-patient only) is responsible for:

- Providing a key point of contact for the bereaved, from the time of death onwards.
- Routinely contacting families 6-8 weeks post bereavement to offer support, or within 2 weeks where the death is referred to HM coroner or where requested by Medical Examiner or clinical team.
- Offering a listening ear, information and an opportunity to provide feedback and raise questions or concerns about the experience of care (as part of the Trust's Learning from Deaths Process).
- Providing signposting to appropriate support organisations (e.g. bereavement counselling) as required.
- Contacts: email uhl-tr.bereavementsupportservicemailbox@nhs.net or call 0116 258 4380/6776 9am-5pm Monday-Friday, excluding bank holidays.

4.8 Nursing Associates / Health Care Support Worker / Students

- Under the supervision of a registered nurse prepare the deceased patient for transfer to the funeral directors.
- Offer support to the bereaved family
- Support the ward clerk or nurse in the management of the deceased's property, in accordance with the Trust procedures (in-patient only).

4.9 Ward Clerks are responsible for:

- Ensuring the deceased patients' case notes/ any paper files supporting electronic patient records are gathered and completed before transfer to Medical Records / Coroner's Office/ Police in accordance with the Information Governance Policy/SARs process.
- In conjunction with the nurse, ensuring the management of the deceased patients' property in accordance with Trust procedures.

4.10 Medical Examiner (ME)

The ME service became statutory in England and Wales on 9th September 2024. Deaths can now only be registered if the death has been scrutinised either by a ME or a Coroner. The stated purpose of the ME system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths.
- Ensure the appropriate direction of deaths to the coroner.
- 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.
- Improve the quality of death certification.
- Improve the quality of mortality data.

The ME process has three parts.

1. Communication (which may be oral or written) between a doctor who may be in a position to certify the death and the ME, as to whether the coroner needs to be informed of the death and, if not, how the cause of death should be recorded.
2. 'Proportionate scrutiny' by the ME of relevant parts of the medical record
3. A conversation with a member of the deceased's person's family, to ensure that the cause of death is understood and to ask whether there were any concerns around the care provided which might justify further consideration.

Following the ME process, where areas of potential learning or good practice have been identified (and relate to hospital practice), these will be discussed and recorded at a Learning from Death (LfD) forum meeting through presentation of the LfD review. (Possible problems outside hospital practice are reported differently). 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.

4.11 Useful contact numbers

Name	Role	Contact Details
Leicester City and South Leicestershire Coroner	Contact in Normal Working Hours If you need to get in contact with the coroner after hours, you can do so by contacting the Leicester Constabulary	0116 454 1030
North Leicestershire and Rutland Coroner	Contact in Normal Working Hours If you need to get in contact with the coroner after hours, you can do so by contacting the Leicester Constabulary	0116 305 7732
Leicester, Leicestershire and Rutland Medical Examiner's Office	Assisting in decisions on coroner referral and cause of death; countersigning MCCDs before transfer to the Registration Office	07815 457565 medical.examinersllr@nhs.net
Leicester City Council Environmental Health	To take responsibility of those deaths in the community (City boundary) where there is no NOK	0116 4543151 (or 0116 4543151 for support line or 0116 373 7327 for Bereavement Services Department)

Name	Role	Contact Details
Blaby District Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	0116 275 0555
Charnwood Borough Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	01509 263151
Harborough District Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	01858 828282
Hinckley & Bosworth Borough Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	01455 238141
Melton Borough Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	01664 502502
North West Leicestershire District Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	01530 454545
Oadby & Wigston Borough Council Environmental Health	To take responsibility of those deaths in the community (District Council boundary) where there is no NOK	0116 288 8961
LPT Chaplains	Spiritual and Pastoral support to patients, relatives and staff.	Via LPT Switchboard.
Muslim Burial Council of Leicestershire	Advice on funeral services	www.mbcol.org.uk Advice: 07801 101786 Out of hours funeral co-ordinator 07803 240493
LPT Corporate Affairs Department	Advice on registering deaths/ finding the NOK/paying for funeral arrangements	0116295 5869
Lee Cooper	LPT Contracted Funeral Directors	01530 814999 The Old Courthouse Belvoir Rd. Coalville. LE67 3PN

Name	Role	Contact Details
LLR Child Death Review Team / LLR CDOP	Oversight of the response to all child deaths and the child death review process, advice on any aspect of the child death review process. Notification of death via eCDOP: www.ecdop.co.uk/llr/public	Melvinna West CDOP Administrator Melvinna.west@nhs.net 07785 5350914 Mon-Friday 09:00-17:00

5.0 Consent

Where possible and appropriate clinical staff must ensure that consent has been sought and obtained from family, friends or carers before any care intervention is delivered.

6.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Method for Monitoring	Responsible Individual /Group	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring
Appendix 10	Any deceased patients subject to MHA have their death reported to the appropriate bodies within the specified timescales.	Audit	MHA group End of Life Care Group	MHA group End of Life Care Group Annual
All policy	Review of incidents / complaints / bereavement support service feedback and quarterly reports / concerns by directorates to identify issues around care of deceased patients, support to relatives and transfer to funeral directors.	Incident and complaint data	End of Life Care group	Bi-monthly reports

7.0 References and Bibliography

- Care After Death, The 10th edition of Royal Marsden Manual of Clinical and Cancer Nursing Procedures, Care after death - Royal Marsden Manual *accessed 18.11.2024*. Copyright © 2000-2024 by John Wiley & Sons, Inc.
- for staff responsible for care after death (2011 and 2015) NHS National End of Life Care Programme Guidelines / Hospice UK
- National Institute for Health and Care Excellence (NICE) (2017) Guideline QS144 *'Care of dying adults in the last days of life'*. London
- National infection prevention and control manual for England. NHS England 2023. National-infection-prevention-and-control-manual-v2-4-250123.pdf (england.nhs.uk)
- https://www.england.nhs.uk/patient-safety/medical-examiners/the-national-medical-examiner-system/
- https://www.hta.gov.uk/guidance-public/body-organ-and-tissue-donation/deceased-organ-and-tissue-donation-transplants
- Child Death Review Statutory & Operational Guidance England (2018)
- Working Together 2023 to Safeguard Children

8.0 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. Training Needs Analysis

Training topic:		
Type of training: (see study leave policy)	Not Required	
Directorate to which the training is applicable:	Adult Mental Health Community Health Services Enabling Services Families Young People Children / Learning Disability/ Autism Services	
Staff groups who require the training:		
Regularity of Update requirement:		
Who is responsible for delivery of this training?		
Have resources been identified?		
Has a training plan been agreed?		
Where will completion of this training be recorded?		
How is this training going to be monitored?		
Signed by Learning and Development Approval name and date		Date:

Appendix 2. 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 Answer yes

Respond to different needs of different sectors of the population yes

Work continuously to improve quality services and to minimise errors yes

Support and value its staff yes

Work together with others to ensure a seamless service for patients yes

Help keep people healthy and work to reduce health inequalities yes

Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance yes

Appendix 3 Due Regard Screening Template

Section 1			
Name of activity/proposal	Care of the deceased patient		
Date Screening commenced	7.11.2024		
Directorate / Service carrying out the assessment	Enabling - Nursing		
Name and role of person undertaking this Due Regard (Equality Analysis)	Emma Wallis, Deputy Director of Nursing and Quality		
Give an overview of the aims, objectives and purpose of the proposal:			
AIMS: This policy and guidance aims to ensure staff can provide professional and compassionate high standards of care following a patient's death.			
OBJECTIVES: Ensuring dignity and respect and enabling effective communication with families and other agencies			
Section 2			
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details		
Age	No negative impact expected for any protected characteristics. The requirements on the bases of cultural, religious and/or beliefs or any other consideration relating to protected groups will be discussed with the person, family, carers, etc. and also, ensuring individual needs are met as per their wishes prior to death. Where the person was not able to discuss their needs prior to death staff will liaise with family, carers and friends to ensure the above are considered.		
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:			
No negative impact identified			
Signed by reviewer/assessor	E Wallis	Date	7.11.24
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	16.01.24

Appendix 4. 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:	**Care of the deceased policy**		
Completed by:	**Emma Wallis**		
Job title	**Deputy Director of Nursing and Quality**		**Date 7.11.24**
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?		Yes	**Coroners**
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 examples, health records, criminal records or other information that people would consider to be particularly private.	Yes	
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:		
Date of approval		

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

Appendix 5.

Declaring Life Extinct and actions to be taken if the death is suspected to be unnatural. (See process maps p8)

Declaring life extinct

- The procedure for assessing the patient for signs of life is detailed in the 'Verification and Certification of Death Policy'.
- The time of the patients' death must be recorded in the patients' record.
- Verification of death must take place before the deceased patient is transferred to funeral services or the mortuary.

Assessing if the Death is Unnatural

- Death is considered to be unnatural where it is immediately apparent that the death did not occur due to natural causes (not ageing or natural illness /disease progression) and that something untoward has occurred to cause the persons death. Examples: accidents (fall, choking), incidents (medication error), suicides.
- Where death is considered to be unnatural it is important to manage the scene carefully to preserve evidence and the Police / Manager / On Call Manager must informed immediately.
- For Children's deaths please also refer to LLR Child Death guidance chart (section 3.5).

Actions to be taken for unnatural death

- Where DNACPR not in place, immediately call the Crash Team / or ambulance and commence resuscitation (as advised by ambulance service). If resuscitation is not successful (resuscitation stopped by a doctor or paramedic):
- **DO NOT TOUCH OR MOVE ANYTHING.** Do not touch anything on the body, the surrounding area or personal effects. If there is any evidence of items being involved in the death, for example rope, clothing, medication, razor blades or items related to drug abuse do not touch or move the evidence.
- If in a communal area screen off the area, if it is a single room lock/ secure the room wherever possible, to maintain the dignity of the deceased patient and prevent the scene being contaminated; post a staff member outside of the room to ensure patients or staff do not enter until the police confirm normal access can be resumed.
- Inform the Police then Line Manager / On Call Manager immediately and follow their instructions.
- **ALL** equipment and dressings must be kept in situ. This includes intravenous lines, central lines, arterial lines, catheters, chest drains, enteral tubes and any disposable equipment.

This equipment should be left in situ but sealed off prior to the collection by the coroners removal services.

- A list of all equipment present at the time of death must be completed and filed in the patient's record. If the Crash Trolley is not implicated in the incident it may be removed and restocked following consultation with the police
- The Police or Coroner may wish a copy from the electronic record within the resuscitation defibrillator. In working hours (Monday to Friday 08.00 till 16.30) contact the Trust Resuscitation Officers via LPT Switchboard. If out of hours please leave a message for the Resuscitation Officers and they will attend on the next working day. The information from the defibrillator is then downloaded by a member of resus team using a special programme and infra- red dongle which connects to the defibrillator to download the information. The Senior Resuscitation Officer then forwards this information to the coroner electronically and will provide a copy with analysis to Trust Investigators.
- The Trust defibrillators store 2 episodes of use therefore if there is a further resuscitation episode before the information is downloaded the defibrillator must be taken out of use and the designated spare defibrillator used.
- **THE POLICE SHOULD NOT REMOVE A DEFIBRILLATOR UNLESS THE EQUIPMENT ITSELF IS SUSPECTED OF CONTRIBUTING TO THE DEATH.**
- **DO NOT PERFORM Care after death/Last Offices**; do not wash the deceased patient, change their clothes or bed linen.
- The deceased patient will be collected by HM Coroner's removal service. If this does not happen or is directed by HM Coroner, the Line Manager / On Call Manager will establish with the Trust funeral services appropriate transfer. The deceased patient should be placed in a body bag and the point of transfer documented clearly on the Notification of Death Form- In-patient only (Appendix 14).
- Preserve the scene of the patients' death until authorised to clear it by the Police / Line Manager / On Call Manager even after the deceased patient has been transferred.

Who should be informed?

- The Line Manager / On Call Manager will inform the Police if they have not been notified on finding the person or by the ambulance service or Nurse in Charge of the ward/community team leader.
- Inform patient's Consultant in working hours or the On Call / Duty doctor or GP if community death.
- Appropriate manager(s) within the department.
- The patients Next of Kin / Relatives / or agreed contacts should be informed and

supported (see Appendix 7 “Communication with the Family”). Communication with the next of kin / relatives should be (in hours) via the team leader (community death) / Matron or Medical staff, or (out of hours) via the On Call Manager or On Call / Duty doctor. It is important to be clear about the procedures and further investigations that are conducted in unnatural circumstances.

- (In-patients only) Explain that under these circumstances family/carers/friends may wish to attend the ward but may not be able to see their relative before removal to the mortuary or the funeral directors.
- The Line Manager / On Call Manager will cascade/ escalate this information as appropriate to the Director / On Call Director and the Executive Team.
- The staff on duty at the time of the incident should complete an incident form (e-irf)
- In-patient only - If the deceased patient is detained under the MHA the appropriate MHA documentation should be completed and relevant statutory bodies informed (See appendix 11).

If the deceased patient is below the age of 18 years the a notification should be completed to the Child Death Review team via eCDOP, flagged as a ‘Joint Agency Response’ (www.ecdop.co.uk/llr/public)

Appendix 6. Referral to H.M. Coroner

Where a death is referred directly to the Coroner, the Medical Examiner's Office should still be notified of all in-patient deaths for their records (see ME / BSS process map)

6.1 Reporting Deaths to H.M. Coroner

The circumstances where a death must be reported to a coroner are set out in The Notification of Deaths Regulations 2019. They are:

(a) the registered medical practitioner suspects that that the person's death was due to:

(i) poisoning, including by an otherwise benign substance.
(ii) exposure to or contact with a toxic substance.
(iii) the use of a medicinal product, controlled drug or psychoactive substance.
(iv) violence.
(v) trauma or injury.
(vi) self-harm.
(vii) neglect, including self-neglect.
(viii) the person was undergoing a treatment or procedure of a medical or similar nature.
(ix) an injury or disease attributable to any employment held by the person during the person's lifetime.

(b) the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph a.

(c) the registered medical practitioner is an attending practitioner in relation to the deceased person; but despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown.

(d) the registered medical practitioner suspects that the person died while in custody or otherwise in state detention.

(e)the registered medical practitioner reasonably believes that there is no attending practitioner in relation to the deceased person.

(f) there is an attending practitioner in relation to the deceased person; but an attending practitioner is not available within a reasonable time of the person's death to prepare and sign an attending practitioner's certificate.

(g)the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

Assistance in interpreting this legislation is available from the Medical Examiner's Office, and Leicestershire's Senior Coroners have stated that all deaths in Leicestershire's hospitals must be discussed with a Medical Examiner before being referred to a coroner.

The Coroner's Offices can be contacted by telephone as detailed in section 4 of the policy.

6.2 Out of Hours contact with the Coroner - Certification and Release of Deceased Out of Hours

- Medical Staff should **NOT** attempt to make contact with the Coroner in respect of body release. Medical staff should contact the Duty / On Call Manager for advice and where appropriate any initial contact **MUST** be made by the Duty Manager.
- Only the Duty / On Call Manager may contact the Coroner and in deciding whether to make contact the Duty / On Call Manager shall consider the following stipulations laid down by the Coroner:-
- If the urgent release of the body of a deceased patient is required out of normal working hours where the doctor believes that the death requires referral to the Coroner, contact with the Coroner can be made via the Duty / On Call Manager ONLY.

6.3 The Coroner can be contacted by the Duty Manager at the following times only:-

a. **Out of Hours Weekdays between the hours of 4pm and 9pm.**
b. **Weekends and Bank Holidays between the hours of 8am and 9pm. There are no exceptions to this rule irrespective of the personal beliefs or age of the deceased.**

- If, following an out-of-hours consultation with the Duty / On Call Manager, the Coroner agrees that the Medical Certificate of Cause of Death can be issued by a doctor, the doctor will be asked to provide contact details of the deceased's next of kin. This is so that the Coroner can confirm with the next-of-kin that they are satisfied with the cause of death before the paperwork is issued to the Leicester Registrar. A death cannot be registered until the Coroner's form has been received by the Leicester Registrar. Needs to be reviewed with Coroner.
- If the patient dies out of hours but there is no need for urgent release, the Coroner should be contacted the next working day.

6.4 Mental Health Act

If the deceased was in custody or was detained under the Mental Health Act where the circumstances of the death are unnatural, including where there is any concern about the care given having contributed to the person's death the body cannot be released and the police must be informed via the Duty / On Call Manager.

It is accepted that medical staff may come under pressure to contact the coroner from the families of deceased. However, the coroner has clearly stated what is required of the Trust

and staff need to be very clear with families that we will adhere to the coroner's requirements.

6.5 Child Death

Refer to the LLR Child Death guidance charts in section 3.5.

If a child dies in hospital and Medical Staff want to seek advice on how to proceed on matters other than body release (e.g. removal of tubes etc.) then contact can be made with the Coroner at the same times as stipulated for **Certification and Release of Deceased Out of Hours** i.e.

a. Out of Hours Weekdays between the hours of 4pm and 9pm.
b. Weekends and Bank Holidays between the hours of 8am and 9pm. Medical Staff should contact the Duty Manager to obtain the Coroner's contact details.

Appendix 7 – Communication with the family/carers

- Relatives always remember the way in which the news of the death of a loved one was broken to them. The way that the news was given and subsequent actions may influence the bereavement experience and grieving process and should be undertaken with compassion and sensitivity.
- Breaking bad news over the telephone is never easy. It is important to tell the truth when giving such sensitive information over the phone and try and support that person as much as possible.

7.1 Breaking bad news

- Prior to informing the next of kin that a patient has died, it is essential to confirm the correct information i.e., that the correct patient and their relatives are identified.
- For those patients having palliative/end of life care, it should already be established how the next of kin wish to be contacted during the day and night.
- In circumstances of unexpected death, informing the next of kin that an accident or sudden illness has occurred and requesting their presence at the hospital can be justified (e.g. where the next of kin was not previously aware of the patient's admission, incident or accident, or where it is understood by those caring for the patient that breaking bad news over the telephone may have a severe detrimental outcome for the next of kin). The intention is to prevent harm and maximise benefit by imparting news in a supportive environment. It is best practice for the Trust to inform the next of kin of the death ASAP. However, in some circumstances, (eg family not contactable) it may be more appropriate to involve the Police, if not already involved, and ask them to support informing the next of kin.
- Information should never be left on an answer machine notifying the family of a death, unless previously arranged with the family. A message should be left asking the family to call the ward.
- An individual's right to confidentiality continues after death. Where the deceased has given instruction to the clinical team preventing them from informing the family of their admission, diagnosis or prognosis, sensitive communication with the family (NoK) should take place after death to inform them of the death and the deceased patient's wishes.
- A summary of communication with the family (with names and relationship to the deceased patient), should be clearly documented in the patient's records.
- Consider the following before making the decision to break bad news over the

telephone:

- Whether it is appropriate to break bad news over the telephone
- Whether you are the most appropriate person to deliver this news
- What knowledge the next of kin / bereaved may have about the patient's condition prior to death.
- When that person last saw the patient
- The age and health of the person
- How far the next of kin may have to travel to reach the hospital and the advisable 4-hour time frame for deceased to remain on ward prior to transfer into the care of the funeral directors.
- Any visiting restrictions in place i.e. in the event of an unexpected or unnatural death the family may not be able to see the deceased before transfer into the care of the Coroner. This decision will be made by the police (follow Care of Deceased process map on p8).
- Language barriers; speech, hearing or language
- Whether they wanted to be contacted over the telephone or during the night / have any previous discussions taken place?

7.2 Once the decision has been made to break the bad news over the telephone:

- It is essential to confirm the correct information, i.e., that the correct patient and their relatives are positively identified.
- Do not imply or state that the patient is alive at the time of the call if they are not, as omitting truth or facts may later appear suspicious.
- Make sure you will not be disturbed or interrupted when making the call.
- Check their location and whether they are alone.
- State who you are when calling and whether you have met or spoken to them previously.
- Acknowledge the difficulty of having this conversation over the phone as this will reduce the negative impact.
- Be direct and clear with the information you give. Confirm that death has occurred – use the words 'is dead' or 'has died'
- Be honest if they ask if the patient has died and give a brief description of what happened.

- Make sure you have time to listen and answer any question that the next of kin/significant person may have.
- Offer that they can phone back later with any questions or queries and provide them with the appropriate telephone number.
- Do they want to see the deceased patient? Not all people do. Are other relatives / friends / important others likely to want to visit. Where the Police are being notified of the death, inform the family of any visiting restrictions in place pending further police guidance (see Care of Deceased process map p8).

7.3 Family visits / time with the deceased – In-patient only

(Follow process chart in section 3.4. Guidance should be sought from the Duty Manager prior to arranging any visit where the death was unexpected and unnatural as visiting restrictions may apply).

Where no restrictions are in place:

- Visits or time with the deceased should ideally not take place in the main ward / area, however the Trust does not have a mortuary facility.
- When the patient has just died, and the family are enroute to the hospital the visit with the patient should be in a single room where possible or a screened area in a shared room with no other patients present. The room should be neat and tidy, and the patient presented in accordance with the last offices guidance. Guidance should be sought from the duty manager and police prior to any visits where the death was unexpected. See process chart in section 3.4.
- The family should be asked if they wish to arrange an appointment or visit at the Funeral Directors and support should be given to arrange this.

Staff should consider their safety when supporting families who may be confrontational, angry or intoxicated; if staff feel their own or other patients' safety is at risk the viewing should be deferred.

7.4 Care of the deceased patient's family and bereavement support

- The experiences of those grieving the bereaved can very much affect the grieving process in the short and long term. The response of relatives and important others are not always going to be the same and may vary significantly. It is important that staff respect and are sensitive to the grief response of relatives and important others.
- It is essential that a lead is taken from the family with regards to their needs. They may have religious or cultural needs that they wish to demonstrate, even if the patient does not have a religion recorded. Chaplains can provide pastoral and spiritual care for

relatives and carers and they may ask to see a member of the chaplaincy or ask to contact a specific person. It is appropriate to ask if they wish anyone else to be contacted.

- In each circumstance, where possible privacy should be offered.
- Family and important others may not wish to see the deceased. Family may wish to speak to a Doctor/Senior Nurse or ask questions regarding the time before the patient's death e.g. 'who was with them' and 'were they in pain'. If this is not directly possible, the Bereavement Support Nurse (In-patient only) or CDOP nurse can assist the family at a later date.
- Do not use medical language. At such times a lot of information is not absorbed by relatives, and it may be necessary to reiterate the information or give them written information.
- Family members should not be rushed to leave the ward / area and refreshments should be offered.
- The family should be offered any bereavement information / guides / Trust bereavement booklets/condolence card (including in-patient booklet, specialist palliative care booklet and Diana booklet). Where the family do not visit in an in-patient setting or present at time of death, these should be sent to the family/carers.
- In an in-patient setting, where the death is natural (or where unnatural only where permitted by police on behalf of the coroner), offer the family an opportunity to receive a lock of hair, and where available a knitted/crochet heart. Pairs of hearts are made by volunteers. One heart remains and is transferred with the deceased patient, the other given to the family. These gestures can support the bereaved with a continuing bond and their grieving process.
- In an in-patient setting, if families want to take a sensitive photograph of the deceased (e.g. their hand holding deceased patient's hand), the nurse must ensure that appropriate safeguards are observed (e.g. curtains/doors are closed) to maintain the confidentiality, privacy and dignity of all patients and staff on the ward. It should be documented in the patient's medical records that a photograph has been taken and the above guidance has been followed.
- Where a photograph has been observed to have been taken which breaches the above guidance, the nurse in charge should sensitively approach the person and request this be deleted. Refusal to comply with this request should be escalated to the Matron or Duty Manager. Further failure to comply should be escalated to the Security Manager and Privacy team.
- Ensure next of kin telephone number and address is recorded on SystmOne.

- In an in-patient setting please share contact details for the bereavement support service nurse with the family, who will routinely call the Next of Kin after 6-8 weeks (in-patient adult deaths only) where earlier contact has not been made. See page 11 for contacts. Referrals requesting early contact with family can be emailed.
- Child deaths - Inform family that they will be contacted by their ‘key worker’ who will provide ongoing bereavement support and signposting to support organisations. The key worker is allocated during a routine initial Child Death Review meeting, usually occurring next or following working day.

7.5 Tissue donation

- The opportunity to discuss with the family and make a referral is presently available in LPT where death was expected, natural and patient was not detained, and where death occurs between 01:00h Monday -12:00h Friday (excluding bank holidays). There is a 24-hour window for tissue retrieval from time of death. Ward Doctors /ANPs will need to make an urgent referral to Medical Examiner – see ME / BSS process map for details.
- Tissues such as skin, bone, corneas, and heart valves can be donated to improve the quality or save the recipients’ life.
- It is important to respect and wherever possible fulfil any known wishes the deceased had regarding tissue donation. Knowing they are helping others and fulfilling their loved one’s lasting wish can also bring comfort to families, supporting their grieving process.
- The new system of consent for organ and tissue donation - known as 'opt-out' or "deemed consent" – was introduced in 2020, meaning Adults in England are considered to have given their consent for organ donation except in the following situations:
  - they decided to not donate their organs and/or tissues
  - they have appointed a representative to decide on their behalf after death
  - they are in one of the excluded groups (under the age of 18; ordinarily resident in England for less than 12 months before their death; lack mental capacity for a significant period before their death).
- The family of the deceased are always consulted first and are able to provide information about their loved one's wishes. If they have information that their loved one would not have wanted to donate their tissues, donation will not go ahead (DoH & SC 2019). Medical conditions preventing organ and tissue donation are CJD, Ebola, HIV, Intra venous drug use, diseased of unknown cause, neuro degenerative diseases (e.g. Parkinson’s/dementia). For organ and other tissue donation cancer is also an exclusion. Cancers (other than blood born cancer) can be considered for corneal

transplant. All referrals are considered on a case-by-case basis. A sample of blood is taken from potential donors to rule out any transmissible disease by the specialist donation team at the funeral directors where required. Further information at **www.nhsbt.nhs.uk**

- Tissue donation can be discussed as part of End of Life conversations and should be sensitively discusses with the family after the death where decisions are not previously know. ‘Suggestion’ of wording:
- ‘’We always aim to respect and wherever possible fulfil any lasting wishes of patients in our care. Are you aware of any wishes your xxx had about tissue donation, and is this something you would like to discuss with a Specialist Nurse?’’
- If ‘yes’, call the National Referral Centre (NRC) on 0800 432 0559 and leave a message. They will return the call (after 8am) to gather more information about the patient, and family contact details. NRC arranges tissue retrieval at the Funeral Directors.
- Family are informed to expect a call from the Tissue Donation Nurse who will let them know if this may be possible. Give tissue donation information leaflet to family.
- Link for tissue donation **www.nhsbt.nhs.uk/tissuedonation**

Appendix 8.

Care after death / Last Offices procedure for adults, children and young people

	Procedure/actions for staff	Rationale
1	**Do not proceed further if the death is considered unexpected or unnatural or has been referred to HM Coroner (including MHA):** The deceased patient may be collected from the place of death by HM Coroner's removal service. Staff should ensure the identification bands are on the deceased patient and document any equipment in use (and batch numbers if available).	Evidence must be preserved for a forensic investigation into the cause of death for the Police and / or HM Coroner.
2	If the Coroner is not involved authority for removal must be given by the Line Manager/ or Duty Manager/ or On Call Manger and the deceased patient placed directly into a body bag and transferred to the Funeral Director. (Removed crem info- no longer relevant) Equipment list: Personal Protective Equipment - Disposable plastic aprons and nitrile gloves (and follow Trust infection prevention guidance for any additional personal protective equipment required to care for the individual patient as required). - Mouth care equipment. - Identification bands (x2) (In-patient only) - Disposable gown or patient's own clothes or nightwear, comply with the patient's wishes, wishes of the family and any cultural wishes. - Bowl, soap, patient's own toiletries, two towels and disposable cloths, comb, nail care equipment - Micropore tape - Clinical waste and domestic waste bag - Valuable/ other property bag (In-patient only) - Clean sheets - Sharps bin - Laundry bin (In-patients) - Receptacle for collecting urine, if appropriate - Documentation for example notification of death form (as per setting)	Personal protective equipment (PPE) for staff to maintain cleanliness, hygiene and prevent the potential spread of infection. To ensure the patient is clean and well presented for viewing by family and transfer to Funeral Director/ Mortuary.

	Procedure/actions for staff	Rationale
	Extra equipment may include: - Dressings, bandages, gauze, stoma bag, cannula bungs, catheter spigots. - Body bag - Suction equipment and absorbent pads (where there is potential leakage)	
3	Put on gloves and apron. Where additional UHL infection prevention guidance / procedure in place during life, continue to follow these after patient has died.	Standard (universal) precautions must be followed for any contact with bodily fluid. To reduce risk of contamination and cross infection.
4	Lay the patient on his/her back with assistance of other member/s of staff, with their arms lying by their side. Straighten any limbs as far as possible (adhering to LPT Manual Handling Procedures and Safer Handling Policy).	To maintain the patient's dignity and for future management of the body, as rigor mortis occurs 2-6 hours after death, with full intensity within 48 hours and then disappearing within another 48 hours. Flexed limbs can cause difficulties with moving and handling into the funeral director's concealment trolley or refrigeration.
5	Remove all but one pillow. Close the mouth and support the jaw by placing a pillow or rolled-up towel on the deceased's chest underneath the jaw. *Do not tie jaw unless otherwise guided by family members.* Remove only mechanical aids such as syringe drivers, etc., and secure the sites with gauze and tape to syringe driver sites and document actions in nursing documentation. All lines must be left in situ and capped off with a blind end cannula bung. **Document all lines left in on the Notification**	To assist with drainage from the head and promote jaw closure. Lines removed after death leak profusely.

	Procedure/actions for staff	Rationale
	of Death form. (In-patient only) Endotracheal tubes (rarely used in LPT) or tracheostomy tubes must not be removed where death is unexpected or unnatural or referred to the coroner. ET/ tracheostomy tubes may be removed if it is clear when death is verified that referral to the coroner is not required. If there is any doubt the tubes must be left in place until referral is clarified. Ensure family are aware ET/ tracheostomy tube has been left in situ and reassure them they will be able to visit deceased without tubes when Coroner's investigations have been completed, either in the Mortuary viewing room or at the Funeral Directors. Ensure that relatives are fully prepared when seeing the deceased's body as to what they will observe in relation to lines etc.	Instruction received from HM Coroner regarding the removal of lines and tubes. To alleviate distress caused by medical devices left in situ. To prevent blood to pool in the fingers and hands as this can be distressing to see.
6	Close the patient's eyes by applying light pressure to the eyelids for 30 seconds.	To maintain the patient's dignity and for aesthetic reasons.
7	If a catheter is in-situ, remove the bag and apply a spigot to the end of the catheter. Use pad and pants to absorb any leakage from the urethra, vagina or rectum Cover stomas with a clean bag	Because the body can continue to excrete fluids after death.
8	If excessive oral leaking of bodily fluids occurs, consider suctioning. Consider body bag if there is excessive body fluid leakage. (In-patient only) **For a community patient please inform the funeral directors if there is excessive bodily fluids and a body bag is required**.	Leaking orifices pose a health hazard to staff coming into contact with the body.

	Procedure/actions for staff	Rationale
9	Exuding wounds should be covered with a clean absorbent dressing and secured with an occlusive dressing. If a postmortem is required, existing dressings should be left in situ and covered with an additional dressing.	Open wounds pose a health hazard to staff coming into contact with the body.
10	Open drainage sites may need to be sealed with an occlusive dressing.	Open drainage sites pose a health hazard to staff coming into contact with the body. If a post-mortem is required drainage tubes, etc, should be left in situ.
11	Consider whether family or carers may wish to be involved in personal care of the deceased patient. Family members must not perform care after death/last offices without a member of staff being present. (In-patient only) Wash the patient and provide nail care, unless requested not to do so for religious / cultural reasons (please refer to sections on individual faiths). Do not shave the deceased. If shaving is necessary, it should be performed prior to death using an electric razor if possible.	It may be important to family and carers to assist with washing, thereby continuing to provide the care given in the period before death. For hygienic and aesthetic reasons. Post-death shaving causes severe burn marks that cannot be disguised by the funeral director, causing disfigurement
12	Clean the patient's mouth using a foam stick to remove any debris and secretions. Clean dentures and replace them in the mouth if possible. If not, ensure they accompany the body. Suction may be necessary to clear fluids from the patient's mouth.	For hygienic and aesthetic reasons. To maintain the integrity of the face shape.
13	Tidy and comb the patient's hair	To maintain dignity
14	Remove all jewelry (in the presence of another member of staff) unless requested by the patient's family to do otherwise. (Release of	To meet with legal requirements, cultural needs and relatives wishes.

	Procedure/actions for staff	Rationale
	property to relatives must be recorded in the Trust property book as per policy). **(In-patient only)** Sikh patients may wear a bangle (Kara) on their wrist, which should not be removed. Baptised Sikhs may also have a small wooden comb (Kanga) and a small ceremonial dagger (Kirpan) which are all religious articles of faith which should not be removed. If jewelry does not come off easily leave it on, secure with tape and document it on the Notification of Death form. **(In-patient only)** Refer to LPT's Management of Patient Property – Policy and Procedure for further details. **(In-patient only)** Consider any other religious ornaments that need to remain with the deceased patient (refer to appendix 9).	
15	Ensure the patient is clothed during transfer to the funeral directors, e.g. night clothes, hospital gown or shroud. Patients should NOT be sent to the mortuary without being appropriately and decently attired unless it is a sudden/ unexpected or suspicious death.	To maintain dignity.
16	In-patient only - Ensure two identification bracelets with the following information are present: - Patient's NHS number - Date of Birth - Name Place one label on the deceased's right wrist, and one label on their right ankle. It is acceptable for this to be their current identification bracelet, and one other. If the right limbs are missing, place identification label on the left limbs.	To ensure the legal, correct and easy identification of the body in the mortuary/ funeral directors.

	Procedure/actions for staff	Rationale
17	**In-patient only** - Complete Notification of Death (NoD) form and bereavement checklist (including addressograph label) and hand copy of NoD form to funeral director when deceased patient is being transferred.	To ensure legal, correct and easy identification of the body in the mortuary/ funeral directors.
18	Sensitivity should be used when preparing the transsexual deceased patient to maintain strict confidentiality of previous gender including discussion with the family.	To comply with the Gender Recognition Act 2004
19	**In-patient** - Non-infectious / non-leaking bodies should be wrapped in a clean white sheet and taped lightly.	To maintain the deceased patient's dignity and to assist moving and handling and protect the decease's body during transfer. Binding the sheet or tape too tightly can cause disfigurement
20	**In-patient** - Body bags should be used for the following cases: a) Patients identified within infection risk table - See Appendix 11. b) Forensic and unnatural/suspicious death including death in custody (place deceased patient in body bag with minimal intervention from nursing staff) c) Recently administered active unsealed source radioactive material for cancer treatment d) Where leakage and discharge of body fluids or faeces is likely (this includes patients with large pressure sores, trauma, burns, gangrenous limbs and infected amputation sites) The deceased can remain unwrapped (i.e. clothed but not wrapped in a sheet) within the bag but, a sheet must be wrapped around the exterior of the bag, allowing the deceased patient to be transferred with minimal risk of tears to the bag. If the exterior of the bag inadvertently comes into	Minimize the risk of transmission of infectious diseases.

	Procedure/actions for staff	Rationale
	contact with potential sources of infection, clean and disinfect the exterior with a Chlorclean solution.	
21	Dispose of equipment according to infection prevention and control principles. Remove gloves and apron and dispose of in clinical waste, wash hands with liquid soap and water and dry with disposable paper towels.	To minimize risk of cross-infection and contamination.
22	**In an in-patient setting** contact funeral director to request transfer of deceased patient. In the community please provide advice and guidance to contact the funeral director. Inform funeral directors of any relevant factors: a) Deceased patient weighing more than 200Kg (If body bag has been used or required if community, including reason why (leaking fluids, risk of infection, radiopharmaceuticals, other) b) In an in-patient setting other ward factors such as ward rounds, catering rounds, drug rounds and visiting times. c) Potential threat of any aggression or conflict (transfer may be delayed until area secure)	Decomposition occurs rapidly, particularly in hot weather and overheated rooms and safe transfer to the mortuary should take place within a reasonable time. Transfer to mortuary/ funeral directors should be within 2-4 hours of death, although sensitivity to family needs must be exercised.
23	In-patient only - Prepare ward area for arrival of funeral directors with concealment trolley by drawing curtains and remove unnecessary equipment to allow the concealment trolley to be placed next to the bed.	To ensure the safe, legal and dignified transfer of the deceased patient to the mortuary.
24	**In-patient only** - Greet funeral directors on their arrival, confirm identity of deceased patient (NHS number on ID bands) and assist with transfer by ensuring bed brakes are locked, bed and trolley are at the same height and pat-slide used for lateral transfer.	To ensure the safe, legal and dignified transfer of the deceased patient to the mortuary/ funeral directors.
25	**In-patient only** - Provide appropriate support and reassurance to other patients and visitors to the ward.	Other patients and visitors may be aware that a death has occurred.

	Procedure/actions for staff	Rationale
26	Record all details and actions within the nursing documentation. Complete an incident form (e-IRF) for all deaths in an in-patient setting, community mental health and child deaths and for unexpected community deaths.	To record the time of death, names of those present, and names of those informed.
27	**In-patient** - All patient property should be stored in individual bags, and properly identified in accordance with “Management of Patient Property Policy and Procedures”. If deceased is under 18 years of age – copy case notes as the death will be subject to review.	Documentation / case notes etc. needed to process the death certificate or property collection.
28	You must ensure that there is a system in place for other professionals involved in the adults/ child’s care to be informed (such as GP, community nurses, Health Visitor, respite home, palliative care team etc.)	To provide ongoing support.

Appendix 9 - Cultural and Religious Requirements

1.1 It is essential that any religious beliefs held by the patient are identified on admission, or at least prior to death, so that nursing staff can seek to accommodate the specific needs of the patient, relatives and important others.

1.2 In planning care, a patient and family centered approach should be taken; it should be remembered that individual requirements will vary even among members of the same religion as well as across cultures. Varying degrees of adherence and orthodoxy exist within all the world's religions and beliefs. It is essential where specific needs are identified, these should be explored with the family as to their preferences.

The family may wish for religious support prior to the patient's death. The identified religion may occasionally be offered to indicate an association with particular cultural and national roots, rather than to indicate a significant degree of adherence to a particular religion.

According to religious tradition, some families may wish for prayers or prayerful music to be played alongside the patient before, during and after death. There may be specific prayers, rites or rituals that are desired or required. There may be many relatives seeking to attend the hospital, Adjustments should be made to allow family members to attend and for these prayers, rites or rituals to be conducted with sensitivity whilst balancing the needs of the clinical environment.

Should a member of staff wish to seek advice or guidance around religious care of a dying patient they may contact the Chaplaincy service.

1.3 When requesting a member of the Chaplaincy for a dying or recently deceased patient, use the following procedure:

- For the Community Hospitals of Leicestershire please refer to the Chaplaincy Folder located on the ward for contact details of specific faith provision such as priests within your local community.

- Should you need assistance from the Chaplaincy service. Call the UHL switchboard on 0300 303 1573 and ask them to contact the chaplain on call. Give your direct dial telephone number to the switchboard operator. A chaplain will call you back. If you have not received a response within 15 minutes please repeat the process.

  Guidance on the requirements for people of different religious faiths can be found on the Trust intranet in the **NHS Staff Multi-faith resource**.

The following table gives indications of additional measures that may be appropriate for various religions.

Bahai 	Bahai relatives may wish to say prayers for the deceased person, but normal last offices performed by nursing staff are quite acceptable. If a special ring is placed on the finger of the patient it should not be removed. There are no specific mandated end of life rituals.
Buddhism 	A request may be made for a Buddhist monk or nun to be present. As there are a number of different schools of Buddhism, relatives should be contacted for advice on how the body should be treated. The relatives may request, for the body to be left for a period of time, while prayers are said.
Christianity 	Relatives may request a priest from their own church to offer prayers and Holy Communion. Roman Catholic families may request the presence of a Roman Catholic priest to perform the Sacrament of the Sick or give Holy Communion.

Hinduism 	A Hindu patient or relative may request the services of a priest during the last stages of life. Where possible the body should not be handled before consulting the relatives. Hindu's often prefer nursing staff of the same sex as the patient to handle the body. The deceased should always be covered by a plain white sheet. Where possible preparation for this eventually should be made by moving the dying person to a single room, so that other patients or visitors are not disturbed by these expressions of grief at the time of death. Support the jaw. Do not remove threads or jewelry. Cremation frequently occurs soon after death, and speedy completion of the death certificate will aid this process.
Muslim 	Many Muslims would prefer to be touched by someone of the same faith and of the same sex. The body should not be washed. The family may request that the body is turned to face towards Mecca (head first). Mecca is South East of Leicestershire. Muslim patients are usually buried as soon as possible after death.

Jainism	The family may wish to provide a plain white gown or shroud for the deceased. Prayers are offered for soul of dying patient- presence of a Jain Spiritual Caregiver is preferred. Family may wish to assist with Last Offices. Prefer no post-mortem unless required Cremation frequently occurs soon after death, and speedy completion of the death certificate will aid this process.
Judaism 	Many Jews would prefer someone from the Jewish faith to touch the body. **Traditionally the body is left for about 8 minutes before being moved while a white feather is placed across the lips and nose to detect any signs of breathing.** The body should be handled as little as possible. The patient should not be washed and should remain in the clothes in which they died. **The family may request the jaw is tied up.** It is often seen as a religious duty for Jewish people to stay with the body until burial.
Mormon (Church of Jesus Christ of the Latter Day Saints) 	Relatives may advise staff if the patient wears a one or two piece sacred undergarment. If this is the case, relatives may dress the patient in these items.
Rastafarian 	Family members may pray at the bedside of the dying person, but there are no rites or rituals before or after death. At death, routine last offices are appropriate. Few would agree to a post-mortem unless it is ordered by the Coroner

Sikhism 	Last rites and prayers may be conducted at the end of life. The eldest son may wish to take the lead for the Last Offices. Do not remove the '5Ks'which are personal sacred objects: Kesh: Do not remove head covering-turban (men)/duppata (women) Kanga: Do not remove semi-circular comb, which fixes hair Kara: Do not remove any bracelets Kachh: Do not remove special shorts worn as underwear. **Seek advice from family if soiled.** Kirpan: Do not remove miniature sword if worn.
Zoroastrian (Parsee)	The family may wish to be present during, or participate in, the preparation of the body. Orthodox Parsees are likely to require a priest to be present. The family may provide specific clothing to be worn, called the Sadra.

Appendix 10 - Patients subject to the provisions of the Mental Health Act 1983

10.1 Requirements to report the death of a patient who is detained or liable to be detained under the provisions of the Mental Health Act 1983 at the time of death.

Duty to inform the Police

The death of any patient who remains subject to the provisions of the Mental Health Act 1983 should always be treated as a 'death in custody' for the purposes of reporting. This applies regardless of the specific detention order and regardless of whether the patient's death is 'expected', 'sudden', 'suspicious' or non-'suspicious' (this list is not exhaustive).

Any deaths under these circumstances should always be reported to the police in the first instance and also to the Coroner local to the place of death as per flowchart 3.4.

Duty to Inform the Care Quality Commission (CQC)

- Under Regulation 17 of the Care Quality Commission Regulations 2009 the Trust is required to report the death of a patient detained under its authority at the time of death. This remains relevant where that authority relates to a death that occurs outside of Trust property. This will include those patient subject to a Community Treatment Order under Section 17a and those who are Absent without Leave under Section 18.
- The following sections of the Mental Health Act are applicable to Regulation 17 reporting:
    - Section 2 – Admission for Assessment
    - Section 3 – Admission for Treatment
    - Section 4 – Emergency Admission for Assessment Section 5(2) – Report on Hospital In-patient Section 5(4) – Nurses' Six Hour Holding Power Section 17 – Leave of Absence
    - Section 17a – Community Treatment Order Section 18 – Patients Absent without Leave
    - Section 35 – Remand to Hospital for Report on Mental Condition Section 36 – Remand to Hospital for Treatment
    - Section 37 – Hospital Order without Restrictions Section 38 – Interim Hospital Order
    - Section 41 – Order Restricting Discharge Section 47/49 – Transfer to hospital of sentenced patients
    - Section 136 – Power of police to remove mentally disordered persons from public places to a place of safety

10.2 Reporting Procedure following the Death of a Detained Patient

In addition to the provisions of the Trust Care of the Deceased Policy staff must ensure that where the death occurs whilst the patient is detained under the Mental Health Act 1983, the following reporting procedure is followed.

The Quality, Compliance and Regulation Team require notification within 24 hours or as soon as practicable after the death has occurred so that statutory notification can be completed with the CQC. The Mental Health Act Office should also be informed.

The team/office will need the following information:

- Patient's name
- Section status (e.g. section 3)
- Ward
- Place of death
- Name of Responsible Clinician
- Name and contact number of informant

Notification and Statutory Documentation

The Quality, Compliance and Regulation team are responsible for notifying the CQC as per Regulation 17: Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983.

NOTIFICATION@cqc.org.uk).

The role of the Care Quality Commission

The Care Quality Commission's statutory responsibility is to keep under review the exercise of powers and discharge of duties under the Mental Health Act 1983 as they relate to the detention of patients liable to be detained. The death of a detained patient may raise issues within the remit of the Commission.

The Commission maintains a database containing information relating to the deaths of patients detained under the Mental Health Act which provides analytical information to assist the work of the Commission.

The Commission also bring to the appropriate notice any failings and/or poor practice in particular cases. They also have a duty to report to the Secretary of State.

The Commission may decide, on reviewing the details of the death as provided in the MHAC3/ Notification of Death document, to visit the relevant hospital. The Commissioner(s) will conduct a thorough examination of all relevant records, including:

- A detailed history of the deceased's Mental Health Act/ DoLS status

- Prescribed medication
- Medical and nursing care before the death occurred.

The visiting Commission's visit should be made known and any relevant staff, or patients, who were on duty or present at the time of the death, should feel able to talk freely and in private to the Commissioner(s) if required.

The Commission will liaise directly with the Coroner in its findings and will attend the inquest in one of a number of prescribed roles dependent on their conclusions.

Appendix 11 – Infection Prevention & Control

11.1 It is important that where a patient dies with a known or suspected infection staff feel confident in correctly handling the body to prevent further spread of infection. Staff must comply with safe handling of such bodies in accordance with Infection Prevention and Control guidance. See appendix 8, carrying out last offices for guidance on infection control measures when handling a deceased patient's body.

- The Trust (Medical, Microbiology and Infection prevention teams) have a legal responsibility to inform the UK Health Security Agency (HAS) when there is a suspicion of or confirmed notifiable disease.
- All those who will have contact with the deceased, should be notified of the potential risk of infection, include next of kin and funeral directors.
- Infection details and advised precautions should be documented on the notification of death form.
- Controlling the risk of exposure in non-employees: religious / ritual preparations. There are considerable variations between people of different faiths, ethnic backgrounds and national origins in their approach to, and practices for death and dying, as regards preparation for burial.
- At the time of death, these practices may require involvement in last offices / first offices. These are essentially the same, ie: closing of eyes and mouth but the former is sometimes carried out when death takes place in hospital. First offices are carried out by the funeral director or their staff. If there is a requirement for involvement, those carrying out the washing, dressing etc of any risks and advise them of the control measures to be used.
- Visiting / viewing: when relatives and others wish to visit the deceased patient, they will need to be advised if there is a risk of infection if they touch or kiss the deceased, as well as advising them of any controls they need to take after contact, for example washing of hands. Certain infectious diseases will present a significant risk, so relatives may need to be discouraged from physical contact and informed of the risks involved. Visiting can still take place at a distance.
- If staff are involved with the care of a deceased patient and are aware or suspect there may be an infection present and the risks of infectivity they can contact the Infection Control Team, Consultant in Communicable Disease Control or Consultant Microbiologist for advice.

11.2 Contact details:	
East Midlands Health Protection Team (Part of HAS) provide specialist public health advice and operational support to NHS, local authorities and other agencies. UK Health Security Agency Seaton House, City Link Nottingham NG2 4LA List of notifiable diseases link http://www.legislation.gov.uk/uksi/2010/659/schedule/1/made	Telephone: 0344 2254 524 (option 1) Out of hours for health professionals requesting urgent advice: 0344 2254 524
Consultant in Infectious Diseases UHL (c/o Infection diseases ward 35 LRI)	0116 2586951
LPT Infection Prevention and Control Team	0116 295 2320

11.3 Table showing transmission based precautions for the deceased patient with infections table (National infection prevention and control manual for England. NHS England 2023)

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Airborne: small particles that can remain airborne with potential for transmission by inhalation							
Plague (Pneumonic and bubonic)	*Yersinia pestis*	3	Yes	Yes	If an appropriate facility is found	Consult specialist advice	Consult specialist advice
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes	Yes	Yes	Yes
Middle Eastern Respiratory Syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes	Yes	Yes
Severe acute respiratory syndromes	eg SARS coronavirus see HSE Handling the deceased with suspected or confirmed COVID-19 - HSE	3	Yes	Yes	Yes	Yes	Yes
Droplet: large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose, or eyes)							
Meningococcal septicaemia (Meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes	Yes	Yes
Non-meningococcal meningitis	Various bacteria including *Haemophilus influenzae* and also viruses	-	No	Yes	Yes	Yes	Yes
Influenza (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes	Yes	Yes
Diphtheria	*Corynebacterium diphtheriae*	2	No	Yes	Yes	Yes	Yes

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Contact: either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	Advised	Yes	Yes	Yes	Yes
Methicillin-resistant *Staphylococcus aureus* (MRSA)	Methicillin-resistant *Staphylococcus aureus*	2	No	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No	Yes	Yes	Yes	Yes
Enteric fever (typhoid/para typhoid)	*Salmonella typhi/paratyphi*	3	Advised	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis, B. arbortus, B. suis*	3	No	Yes	Yes	Yes	Yes
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxin producing *E.coli* (eg O157:H7)	3	No	Yes	Yes	Yes	Yes
Contact: either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired Immune Deficiency Syndrome related illness	Human immune-deficiency virus	3	No	Yes	Yes	Yes	Yes
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[4]	No	No
Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes	Yes	Yes
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	See appendix 11b	4	Yes[5]	No	No	No	No
Contact: either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							
Transmissible spongiform encephalopathies (eg vCJD)	Various prions	3	Yes	Yes	Yes	Yes	No

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is (or is likely to be) leakage of bodily fluids.

[2] When carrying out higher risk procedures such as post-mortem or embalming, consideration should be given to the need for additional measures to prevent contamination of equipment

Infection	Causative agent	Hazard Group	Is a body bag needed[1] ?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]

and the environment and to prevent staff exposure to infectious material eg through additional PPE and use of safer sharps devices.

[3] Hygienic treatment refers to washing and/or dressing of the deceased.

[4] Where anthrax infection is suspected, before undertaking a post mortem the rationale for the procedure should be carefully considered; particularly where examination may increase the potential for aerosol generation.

[5] A double body bag must be used.

NB Hazard group 4 and HCID will be transported by HART teams (see section 2.6)

Appendix 12 – Making and paying for funeral arrangements.

12.1 Who is responsible for registering a death?

This is usually done by a family member. If there is no family the death can be registered by :

- any person present at the time of death
- an administrator from the hospital (if the person died in hospital).
- the person in charge of funeral arrangements.

The death should be registered with the registrar of deaths within the 'registration district' where the patient died, and should take place within five days of the Registrar receiving written notice (Medical Certificate of Cause of Death) from the Medical Examiner's office or Coroner.

12.2 Who is responsible for arranging a funeral?

Where the deceased's estate comprises of sufficient funds to pay for the funeral, responsibility for arranging this lies with the deceased's Personal Representatives. Where the deceased left a Will, the Personal Representatives will be the executors named in the Will.

Where there is no Will, family members are entitled to apply to be appointed as Administrators, at which point they become the Personal Representatives. Strictly speaking, they are not Personal Representatives until formally appointed by the Probate Registry and named on a Grant of Letters of Administration. By convention, prior to appointment, they are able to deal with matters such as the funeral that require urgent attention.

Where neither are appointed, it is usual for close family (eg spouse, civil partner) to make funeral arrangement, or the closest family or friends in agreement with any living spouse or civil partner.

There is a strict order of priority which determines the family members that are entitled to apply to act as administrator. That order is:-

- Surviving spouse or civil partner.
- Children of the deceased.
- Grandchild of the deceased.
- Parents of the deceased.
- Brother or Sister of deceased.
- Nephew or Niece.
- Other relative.

Under section 46 of the Public Health (Control of Disease) Act 1984 it is the duty of the Local

Authority to arrange the burial or cremation of a person found dead in their area, when it appears that no suitable arrangements are otherwise being made. The Local Authority may recover the expenses of arranging funerals in accordance with this provision from the deceased's estate. (The Local Authority may not cremate a body if it has reason to believe that this would be contrary to the deceased's wishes).

Public health funerals should be arranged if no-one else is prepared to make the arrangements because:

- Relatives cannot be traced, or
- Relatives cannot afford to pay for the funeral and/or do not qualify for Social Fund Funeral Payments, or
- Relatives are unwilling to take responsibility for the funeral arrangements.

In line with the government guidance, NHS Trusts should develop their own policy which takes into account their Local Authority protocol and work together to ensure a respectful burial or cremation is delivered as efficiently as possible where a death occurs in hospital. Where a patient who dies in LPT requires a public health funeral arranging, they will be transferred into the care of the hospital contracted funeral director (Lee Cooper). The ward Matron and bereavement support nurse should be contacted, who will liaise with the Trusts Corporate Governance team.

12.3 What steps should LPT take following the death of an in-patient in relation to the funeral?

At first instance LPT should contact known relatives as they should organise the funeral. If relatives are not sure who is responsible then LPT might advise them that the executors named in any Will are primarily responsible, followed by family members in the order set out above. If there is a dispute between the relatives about who is entitled to arrange a funeral then staff should take specific legal advice from the Trust's Corporate Governance Dept on the position before releasing the body.

A funeral can be paid for:

- from a financial scheme the person had, for example a pre-paid funeral plan or insurance policy
- by family members or friends (www.gov.uk provides information on eligibility and applying for funeral expenses payments)
- with money from the person's estate

In-patient - If LPT is holding sufficient funds on behalf of the deceased to arrange the funeral then it should make the family or the Local Authority aware of this. The family may ask for the funeral directors' invoice to be paid out of those funds, which would be fine. In the case of the Local Authority, it may claim against any funds held for its costs. The Local Authority will ask LPT to arrange the funeral and pay for it out of the funds held.

Where funds are not held by LPT but the deceased may have funding within their estate to pay for the funeral, the bereavement support nurse will liaise with the Corporate Governance team, and a decision will be made on a case-by-case basis whether the responsibility for coordinating funeral arrangements will be transferred to the University Hospital of Leicester NHS Trust (UHL) Bereavement Services Department, whereby a house search may be arranged and funeral costs incurred may be recouped from the estate in accordance with the UHL Policies (Organising Hospital Contracted Funerals for Deceased Adult patients B11/2010, and Recouping the Costs of Hospital Funerals from the Estates of Deceased Patients (B12/2010) .

LPT would be invoiced for this service along with any outstanding funeral costs incurred, which is payable from the relevant Directorate funds.

12.4 In-patient - What should LPT do if it holds funds belonging to the deceased? Who can personal belongings and cash be released to?

Any assets belonging to the deceased should only be released to the Personal Representative: either the executor/s named in the Will or the family member with highest priority on the list in section 13.3. The Trust Corporate Affairs Dept are to be contacted by the service to take this these matters of assets disposal forward.

In order to confirm that LPT is dealing with the Personal Representative, it is entitled to ask to see an official copy of the Grant of Probate (where there is a Will) or of the Grant of Letters of Administration (where there is no Will, or where the executors named in the Will are unable to act). The official copy of the Grant will have an imprint of the Court Seal and will name the Personal Representative/s.

For small sums or assets of little value LPT may take the view that it is not worth insisting upon sight of the Grant of Probate or Letters of Administration. In those cases it should ask to see the Will to confirm who the executors are, or should ask for confirmation of living family members to ensure that they are dealing with the correct person. The person should be asked to provide LPT with an indemnity, so that if it subsequently transpires that a different person proves to be the proper Personal Representative, LPT can claim back any losses from the person they originally dealt with.

When LPT is holding sums and there appear to be no family or executors, then LPT will refer the case the Treasury Bona Vacantia division of the Treasury Solicitor.

Care of Deceased Policy Appendix 13

Death Notification Form & Bereavement Care Checklist – Inpatient only

Page 1&2: Original copy retained in notes, 1 copy given to Funeral Director

Pages 3-7: Bereavement check list retained in patient notes.

Directorate	**(Circle) CHS / MHD / FYPCLD**
Hospital & Ward	
NHS number	
Date & time death **identified**	
Identifier name & designation	
Date & time death **verified**	
Verifier name & designation	
Death was (circle answer)	**Expected / Unexpected**
Death was natural? (i.e., due to aging process or progression of natural illness/disease)	**(Circle) Yes / No**

Patient Full Name & Address

Follow 'Care of Deceased Process Map' within this policy.

Is patient detained under Mental Health Act 1983?	**(Circle) No / Yes:** **Section: Commenced on:**
Next of Kin (Nok)	**Name:** **Relationship:**
NoK telephone numbers	1. 2.
Relatives aware of death?	**(Circle) Yes - Present at death / Aware / Visited after death.** **No - Give details of attempts made to contact relatives:**

Care of Deceased Prepared for transfer by:	**1.** **2.**
Dentures in situ?	**(Circle) N/A / Top / Bottom / Both**
Jewellery/other items in situ?	**(Circle) No / Yes - Details:**
Implantable device in situ?	**(Circle) No / Yes – Details (e.g. pacemaker):**
Lines/drains /tubes in situ?	**(Circle) No / Yes - Details:**
Infection control status & relevant information:	**Details:**
Skin intact?	**(Circle) Yes / No – Details:**
Transfer arranged to:	**(Circle) Trust contracted Funeral Directors / Family's chosen Funeral Directors** **Name and contact details:**
Family requested referral to Tissue Donation team? (Where death **expected** and **natural** only)	**(Circle) NA / No / Yes - Call Tissue donation team: 0800 432 0559** **Time and date called……**

Transfer of Care to Funeral Director

Patient transferred at:	**Time:** **Date:**
Funeral director to sign:	**Print Name:** **Signature:**
Nurse present to sign:	**Print Name:** **Signature:**

In Patient Bereavement Care Check list – to be used alongside the Care of the Deceased Policy			
	Action	**Rationale**	**Date + initial when complete (or N/A)**
1	1.1 Follow '**Care of Deceased Process Map'.** For further advice: **<u>In hours</u>** – liaise with senior manager or Responsible Doctor. **<u>Out of hours</u>** – on call Ward Sister or Charge Nurse/ Manager - Switchboard 0116 2256000 On call Responsible Doctor / 'Out of Hours' Service 0300 3230672	Guidance received from HM Coroner and Leicestershire Police October 2024.	
2	**<u>Informing family</u>**. 2.1 Natural death – Where family not present, nurse phones and sensitively notifies next of kin patient has died and invites to visit. Explain 4-hour advisable (flexible) time frame for deceased to remain on ward. 2.3 Unnatural death - discuss with Matron/on call Manager who will advise and support calling family as required. Visiting restrictions to be sensitively explained to family. 2.4 If family intending **not to visit**, also discuss numbers 7,8,9 (and 10 where death occurs between 01:00hrs Monday-12:00hrs Friday and is not expected to be referred to the coroner). Send bereavement booklet to family. Document discussions with family on Systmone.	2.1 Family can make informed decision regarding visiting on ward or funeral directors where lengthy journey expected. Body changes occur after death. Patient will require refrigeration at funeral directors. 2.3 Restrictions to bedside visiting may be required to preserve evidence. Manager and Police will advise. 2.4 Families require clear information regarding what will happen next and what they need to do.	
3	**<u>Verification of Death</u>** 3.1 completed as per policy by doctor or nurse trained in process. If a verifier is not available out of hours, call the 'Out of Hours' Service 0300 323 0672 **Gillivers / Grange** medical cover is provided by the Bradgate Unit. Contact via switchboard 0116 2256000	3.1 Legal requirement	
4	**<u>Where no family</u>** – Inform Matron and email Bereavement Support Nurse uhl-tr.bereavementsupportservicemailbox@nhs.net	Hospital Funeral will need to be arranged.	
5	**<u>When family arrive.</u>** 5.1 Welcome family, offer condolences and take into private area to prepare them for visiting (i.e., answer any initial questions, explain how patient looks, and environment). Ask if they want anyone contacting. Where police not involved, accompany family to bedside. Offer: privacy, time with the patient,	5.1 The experience of the bereaved can affect their grieving process.	

	refreshments, ongoing compassionate support, chaplaincy contact. 5.2 Where police involved, sensitively explain any restrictions in place.	5.2 Preserves evidence for Police / Coroner investigation.	
6	**<u>Last Offices/ Care after Death</u>** - Perform **only** if death was **expected, natural and patient not detained.** Invite family involvement and support cultural / religious needs.	Family can make informed choice regarding their involvement.	
7	**<u>Preferred Funeral Director and Funeral.</u>** 7.1 **Where police not involved or Police have given permission**, make arrangements to transfer the patient into the care of the family's chosen funeral director. Where family have not chosen a funeral director (or patient has no family), arrange transfer to the LPT contracted Funeral director: Lee Cooper telephone – 01530 814999.	7.1 Where transfer to LPT contracted funeral director arranged, family may arrange transfer to another Funeral Director at later date (may incur cost). Police will advise if patient requires collection from place of death by HM Coroner's service.	
8	**<u>Urgent release of body requests (</u>**e.g., Muslim / Jewish faith, Tissue Donation) 8.1 **In Hours**- ANP/doctor sends completed Medical Examiner (ME) referral template (available on SystmOne) and supporting information to ME mailbox and **calls** the ME Office to alert them. 8.2 **Out of Hours**: doctor or duty manager contacts UHL Medical Examiner Officer via UHL switchboard- 0300 303 1573. 9am-9pm. (See ME/BSS Process flow chart)	8.1 Supports cultural and religious needs of family. ME Officer will liaise with doctor, ward, and ME and assist in expediting release wherever possible.	
9	Inform family **<u>'what happens next'</u>:** 9.1 Where a death is not being referred directly to the coroner, the **family should expect a call from the ME Office** over the following 1-3 working days to discuss the proposed cause of death and certification process. Families are contacted by the ME Office and informed if the death can be registered or is being referred to the coroner. 9.2 Where direct referral to the coroner is being made by the police or medical team (e.g. unnatural death), family will not be called by the ME Office and should be informed to expect a call from the Coroner's Office over the following days. The Medical certificate cannot be completed. 9.3 Where a Coroner referral is not required, the ME and doctor complete the **Medical Certificate of Cause of Death (MCCD). Family do not need to collect this from the hospital.**	9.1 All deaths are referred to the Medical Examiners, who are senior medical doctors contracted to provide independent scrutiny of the causes of death. They will agree a proposed cause of death 'to the best of knowledge and belief' with the doctor or request a Coroner referral is made. Where the death is not being referred to the Coroner, the ME will contact the family to ask if they have any questions/concerns about the cause or circumstances of the death before authorising the release of the Medical Certificate. 9.2 Coroner's Office will call family to explain next steps. 9.3 The MCCD is sent electronically to the Registrar's Office**.** 9.4 A funeral date cannot be set until a Death Certificate (or Coroner's Interim Death Certificate) is issued. 9.5 <u>UHL Bereavement Services Offices</u>:	

	9.4 Family may make funeral arrangements, but no date should be set until the death has been registered. 9.5 On receipt of the MCCD, the **Registrar will contact the family** to arrange registration and collection of the Death Certificate within 5 days. ***NOTE:*** **Where UHL are issuing MCCD- contact Bereavement Services Office for guidance**	LRI - 0116 258 5196/4 Glenfield – 0116 258 3401 LGH - 0116 258 4234/5	
10	**Tissue Donation** 10.1 The opportunity to make a referral is presently available where death was **expected, natural** and **patient was not detained**, and where death occurs between **01:00h Monday - 12:00h Friday** (excluding bank holidays). 10.2 Sensitively discuss and offer to family. **'**Suggestion**'** of wording: **''We always aim to respect and wherever possible fulfil any lasting wishes of patients in our care. Are you aware of any wishes your xxx had about tissue donation, and is this something you would like to discuss with a Specialist Nurse?''** If 'yes', call the National Referral Centre (NRC) on **0800 432 0559** and leave a message. They will return the call (after 8am) to gather more information about the patient and family contact details. NRC arranges tissue retrieval at the Funeral Directors. Family informed to expect call from Tissue Donation Nurse and Tissue Donation who will let them know if this may be possible. Give information leaflet to family.	10.1 There is a 24-hour window for tissue retrieval, from time of death. Ward Doctors /ANPs do not cover 24/7 and will need to make an urgent referral to Medical Examiner asap after death (electronic and by phone) – see ME / BSS process map for details. 10.2 Tissues such as skin, bone, corneas, and heart valves can be donated to save and improve the quality of life for many people. It is important to respect and wherever possible fulfil the wishes of the deceased where they have made it known to families that they would like to be a donor. Knowing they are helping others and fulfilling their loved one's lasting wish can bring comfort to families. The new system of consent for organ and tissue donation - known as 'opt-out' or "deemed consent" – was introduced in 2020, meaning Adults in England are considered to have given their consent for organ donation except in the following situations: • they made a decision to not donate their organs and/or tissues • they have appointed a representative to make a decision on their behalf after death • they are in one of the excluded groups (under the age of 18; ordinarily resident in England for less than 12 months before their death; lack mental capacity for a significant period before their death). The family of the deceased are always consulted first and are able to provide information about their loved one's wishes. If they have information that their loved one would not have wanted to donate their tissues, donation will not go ahead (DoH&SC 2019). Medical conditions preventing organ and tissue donation are CJD, Ebola, HIV, Intra venous drug use, diseased of unknown cause, neuro degenerative diseases (e.g. Parkinson's/dementia). For organ and other tissue donation cancer is also an exclusion, but for corneal transplant, cancers (other than blood born cancer) can be considered. All referrals are considered on a case-by-case basis. A sample of blood is taken from potential donors to rule out any transmissible disease by the specialist donation team. Further information at www.nhsbt.nhs.uk.	
11	**Property**- invite family to take this home, or arrange for later collection	Follow Patient Property Policy & guidance	
12	**Adult death - Complete details on inner front cover of 'Helpful information following a death**	Provides guidance and support. Website details:	

	in hospital' bereavement booklet and give to family. **Post to family if not attending hospital or share website details where booklet is available.** Easy Read booklet 'When someone dies in hospital' also available.	https://www.leicspart.nhs.uk/contact/patient-advice-and-liaison-service-pals/useful-links-for-support-information/ Easy Read: https://www.leicspart.nhs.uk/wp-content/uploads/2024/08/655-easy-read-When-someone-dies-in-hospital.pdf	
13	**Bereavement Support** 17.1 **ADULT DEATHS**- Offer contact details and inform family that the **Bereavement Support Service (BSS) Nurse** can be contacted to access support and will routinely call them after 6-8 weeks. (0116 258 4380). If earlier contact required, please email: uhl-tr.bereavementsupportservicemailbox@nhs.net **17.2 Ensure NoK contact number and address on SystmOne**. 17.3 **Condolence card** Patient's Nurse writes card and sends on behalf of the ward team to NoK on day of death (to be received 2-3 days later - BSS contact details are on the back). Email CHS Hospitals EoL Lead Matron or Bereavement Support Service for stock of cards uhl-tr.bereavementsupportservicemailbox@nhs.net 17.4 Knitted hearts (donated by volunteers - where available): 1 to stay with deceased, and one given to family. 17.5 Ask family if they would like a **lock of hair**. 17.6 If families wish to take sensitive photographs (e.g. their hand holding deceased patient's hand), ensure that no images of other patients (or staff member without full consent) are captured. 17.7 **CHILD DEATHS** – Inkless handprints may also be taken at family's request, where available. Inform family that they will be contacted by their '**Key Worker'** who will be allocated to support them during their bereavement.	17.1 Family should have access to appropriate support and an opportunity to offer feedback about care and/or raise questions and concerns after a bereavement. 17.2 Bereavement Support Nurse will write to family if not contactable by phone if address available. 17.3 Compassionate gesture appreciated by families and provides bereavement support contact details. 17.4 – 17.7 Memory making and continuing bond supports grieving process. To offer where police permit or not involved. 17.7 Key worker is allocated during the initial Child Death Review meeting, usually occurring next or following working day.	
14	**Notify GP** of death and those services planning contact with family e.g. social care /discharge team/ community teams. **Where 'Adult' Palliative Care involved- call 0300555255**	Supports timely cancellation of planned contacts/visits and prompts supportive contacts with family.	
15	Nurse completes **eIRF for all deaths.** Expected death recorded as **no harm.** Unexpected death, record as **catastrophic.** **Also document if patient has no family.** **In DMH**, record all deaths as **catastrophic**	Auditable information captured on LPT system 'Ulysses' In DMH, this triggers patient care review.	

16	**SystmOne update –** discharge patient and cancel pending tasks (refer to SystmOne discharge guide)	Notifies MDT of death	
17	**ALL Child deaths (under 18 years) –** Ensure **responsible doctor** completes electronic referral to '**Child Death Overview Panel'** (CDOP) as soon as possible and within 24 hours ***https://www.ecdop.co.uk/*** **LLR/live/login** *Click on the GREEN button*	It is a statutory requirement that all child deaths are reported to and reviewed by CDOP	
18	Where patient had Learning Disability or Autism (18 years+), doctor or member of LD Acute Liaison Nurse Team to complete on-line notification form within 24 hours for 'Learning Disability Mortality Review' (LeDeR). Email LD team mailbox **llr.lederadmin@nhs.net** Notification Link: Report the death of someone with a learning disability (leder.nhs.uk)	National requirement which triggers review of care to better understand the needs of people with a learning disability or autistic people and to improve future services.	
19	**Notes –** Ward clerk /designated other, scans any paper notes to SystmOne. Where notes not required by UHL for certification, or LPT for Coroner referrals /reviews, post to: LPT Scanning Team, Room 500, Rutland Building, County Hall. Leicester Road. Glenfield. LE3 8RA. All UHL notes to be sent to LRI Bereavement Services for the attention of the Medical Examiner.	Electronic record kept	
20	**For patients detained under Mental Health Act 1983** – will require referral to Coroner. Follow policy guidance on 'Reporting Procedure following the Death of a Detained Patient' (e.g., inform MHA Office of death within 24 hours - via switchboard and CQC Notification form). Referral to Coroner where patient detained under Deprivation of Liberty Act – Safeguard, no longer needed. Form 12: Notification of death whilst deprived of liberty. This form is sent to the Local Authority when a patient has died and is under a Form 1 Standard or Urgent Authorisation or a Form 5 Standard Authorisation (available on SytmOne).	Statutory requirement Follow DoLs Policy	

Nurse in charge to print name and sign when all actions completed ……

Date & Time ……

Appendix 14: LPT In-Patient Deaths - Medical Examiner (ME) /Bereavement Support Service (BSS) Process Map

1a. Medical Examiner Officer (MEO) to be notified of ALL deaths. LPT ANP/doctor completes and emails ME referral proforma (available on SystmOne) to the Leicester, Leicestershire & Rutland Medical Examiner NHS Net mailbox at medical.examinersllr@nhs.net). Phone: 07815 028098 or 07815 457565

1b. Additional information required: 1- Copy of ReSPECT form 2- Copy of discharge letter if admitted from non-UHL hospital.

1c. Confirm where Cause of Death discussion with the Medical Examiner (ME)/completion of Death Certification paperwork will happen (if known) i.e. in one of UHL's Bereavement Offices or at the LPT Hospital and provide contact details.

1d. ME Officer (MEO) prepares/presents proforma to ME. - MEO will contact LPT referrer if further info needed or LPT records not showing on SystmOne.

NOTE: LPT clinical team to also call ME Office where 'urgent release' or 'tissue donation' requests are made by family.
Where Police have referred death to Coroner, Responsible Clinician should still contact the Medical Examiner to discuss clinically.

2a. Medical Examiner (ME) discusses care and cause of death with Certifying Doctor + proportionately screens available paper/electronic records. mailbox)

3a. Where agreed MCCD can be issued,
Certifying doctor completes MCCD - if MCCD completed at LPT hospital, Admin send scanned copy to medical.examinersllr@nhs.net
Clinical Medical Examiner Officer (CMEO) or ME calls family to explain cause of death.
Where no significant family concerns are raised – i.e., preventing MCCD being issued, CMEO or ME informs family about bereavement support available:
- Adult deaths- BSSN will contact family in **6-8 weeks** or will offer earlier contact where indicated i.e. distress / concerns (family may contact BSSN anytime).
- Child death – Child Death Review Nurse and allocated 'Key Worker' will contact family in following days.
If significant family concerns raised, certifying doctor is contacted by MEO to organise Coroner Referral (see 3b & 4b)

3b. Where MCCD cannot be issued, family are informed of referral to Coroner by MEO and that:
- Adult death - BSSN will contact them within 2 weeks (or family can contact BSSN earlier).
- Child Death –Child Death Review Nurse and allocated 'Key Worker' will contact family in following days.

4a. Where MCCD can be issued (same or next working day- dependant on ME being able to contact family):
i. ME countersigns MCCD which is then scanned and sent to the Registrar by MEO (or BSO if completed in UHL Bereavement Office)
ii. MEO emails completed ME Proforma to LPT containing outcomes of ME screening, discussion with certifying doctor, proposed cause of death and any ME or family feedback (questions / concerns /compliments).
Iii Email also advises of agreed BSS Nurse follow up contact time. Email copied to:
- LPT LfD Team: lpt.learningfromdeaths@nhs.net for reference
- BSS mailbox: uhl-tr.bereavementsupportservicemailbox@nhs.net (to action questions / concerns where)
- llr.lederadmin@nhs.net if deceased had Learning Disabilities or Autism

4b. Coroner Referral required:
MEO liaises between UHL Bereavement services and LPT clinical team to confirm which Coroner's Office and who best placed to complete referral.
emails completed ME Proforma confirming MCCD cannot be issued and highlighting any ME concerns to:
- Doctor responsible for completing Coroner referral
- Notifying ANP/ Doctor - for reference
- LPT LfD: lpt.learningfromdeaths@nhs.net
- llr.lederadmin@nhs.net if deceased had Learning Disabilities or Autism
- BSS mailbox: (triggering early contact with family). uhl-tr.bereavementsupportservicemailbox@nhs.net

If referral being completed in UHL Bereavement Office, Doctor liaises with BSO team for support with referral.
If referral being completed at LPT site, MEO supports as needed and sends link to Coroner Referral Portal
MEO to check which coroner office -North/South and access copy of Coroner referral form or Coroner portal details and completes referral for the BSO / MEO to send to Coroner Office.

5. Adult deaths - BSSN contacts bereaved family (designated or actual NoK):

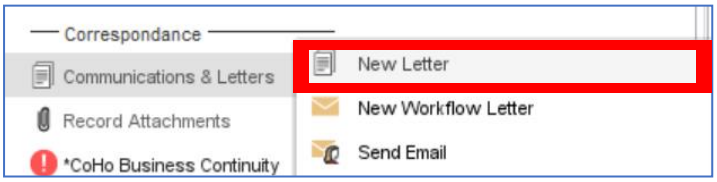
- Offers a listening ear, identifies where there are unmet bereavement needs, signposts /refers to appropriate support organisations as required, invites families to provide feedback about the standard of End-of-Life care and sends feedback/compliments to the team.
- Where family raise questions / concerns, and BSSN is unable to independently resolve, (and these have not previously been raised by the family via the formal concerns /complaints route) the BSSN will advocate for family and will:
  - Provide **FEEDBACK** to clinical team.
  - Request **REVIEWS** of care or meeting with clinical team via appropriate and family's chosen pathway - or where concerns already requested/escalated by ME, forward any additional family feedback for consideration. Escalate to Patient Safety Team as required.
  - Shares clinical team responses/ review feedback with the family via their preferred method e.g. verbal, written, meeting.
  - Where requested by the family, signpost or assist in raising a formal concern/complaint.

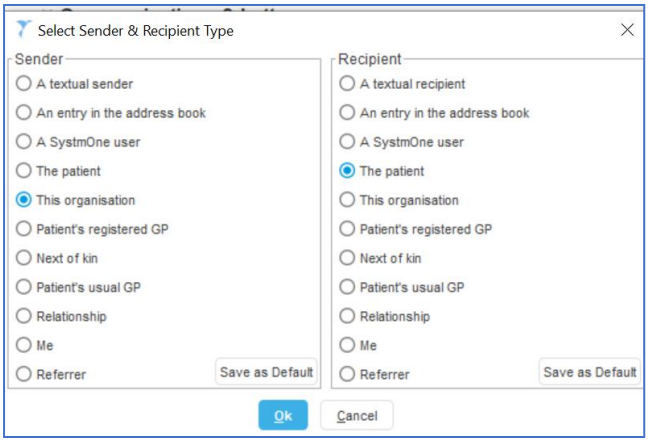
Child deaths: CDR Nurse & allocated Key Worker offers bereavement support and assists family in raising questions/concerns as part of the CDOP process.

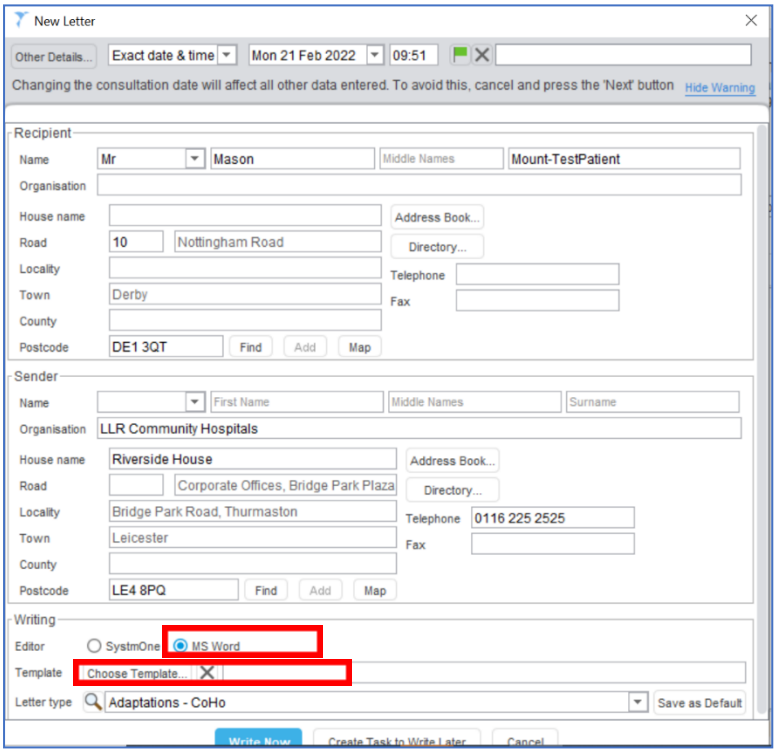
Contacts: **Rebecca Broughton** – UHL Head of Learning from Deaths. Rebecca.broughton13@nhs.net contact via UHL switchboard 0300 303 1573. **ME Office** - LRI 07815 028098 or 07815 457565 (9am-5pm Mon-Friday, excluding bank holidays). **ME Office - Out of Hours** (available every day 9am-9pm) - 07971 745188 or via UHL switchboard 0300 303 1573. **Bereavement Services Office** - LRI 0116 258 5194 (9am - 5pm Monday to Friday, excluding bank holidays**). Bereavement Support Nurse** - 0116 258 4380/6776 – uhl-tr.bereavementsupportservicemailbox@nhs.net (9am - 5pm Monday to Friday, excluding bank holidays).

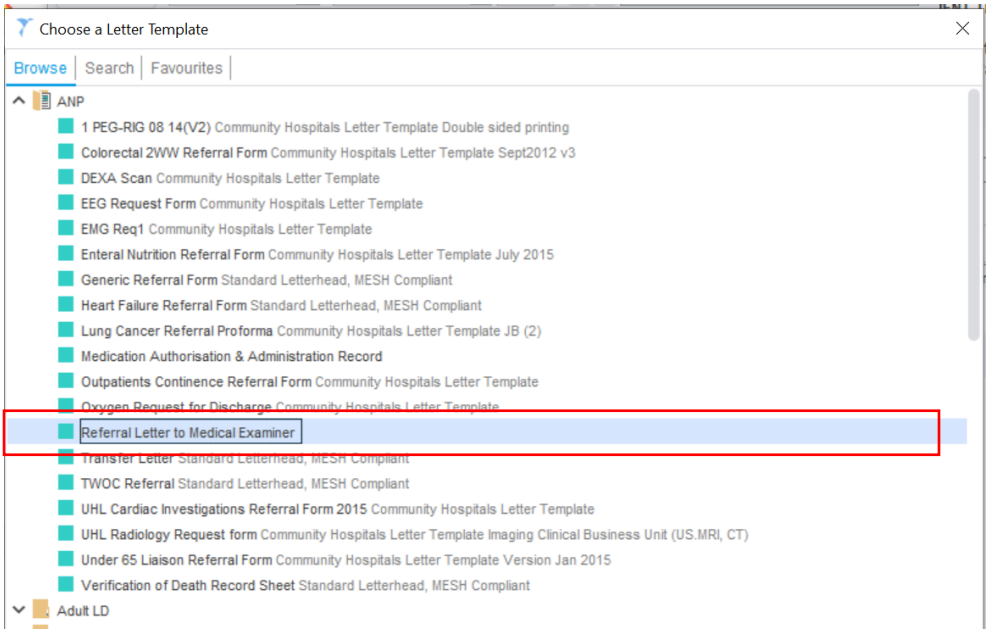
Guideline written by Rebecca Broughton and Kim Sanger 1.8.23, updated 22.1.24. 6.2.24. 16.2.24, 27.2.24, 22.3.24, 9.9.24, 16.9.24, (7.10.25 + 6.3.26 email updates)

Appendix 15- SystmOne Medical Examiner referral guidance – In-patient only (CHS ANP's and available for use for across LPT as needed)








Choose a Letter Template
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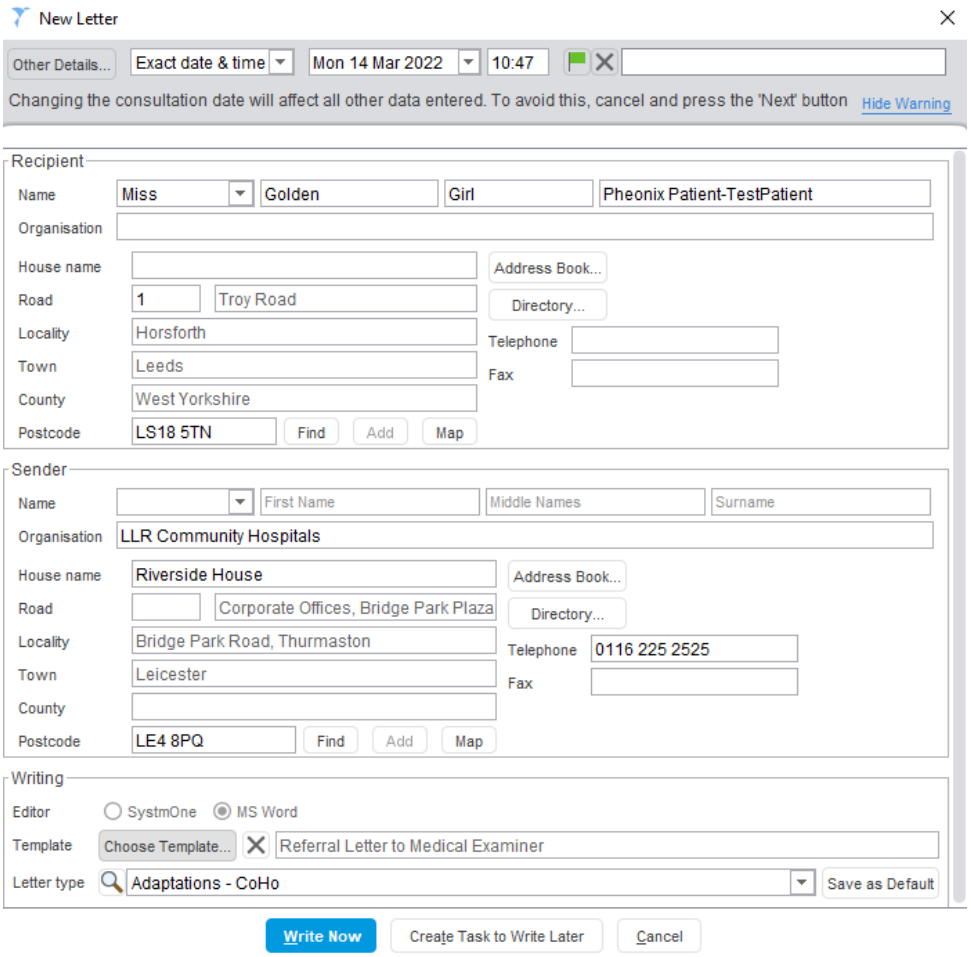
ANP
1 PEG-RIG 08 14(V2) Community Hospitals Letter Template Double sided printing
Colorectal 2WW Referral Form Community Hospitals Letter Template Sept2012 v3
DEXA Scan Community Hospitals Letter Template
EEG Request Form Community Hospitals Letter Template
EMG Req1 Community Hospitals Letter Template
Enteral Nutrition Referral Form Community Hospitals Letter Template July 2015
Generic Referral Form Standard Letterhead, MESH Compliant
Heart Failure Referral Form Standard Letterhead, MESH Compliant
Lung Cancer Referral Proforma Community Hospitals Letter Template JB (2)
Medication Authorisation & Administration Record
Outpatients Continence Referral Form Community Hospitals Letter Template
Referral Letter to Medical Examiner
TWOC Referral Standard Letterhead, MESH Compliant
UHL Cardiac Investigations Referral Form 2015 Community Hospitals Letter Template
UHL Radiology Request form Community Hospitals Letter Template Imaging Clinical Business Unit (US.MRI, CT)
Under 65 Liaison Referral Form Community Hospitals Letter Template Version Jan 2015
Verification of Death Record Sheet Standard Letterhead, MESH Compliant
Adult LD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Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button
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Recipient
Name
Miss
Golden
Girl
Pheonix Patient-TestPatient
Organisation
House name
Road
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Troy Road
Locality
Horsforth
Town
Leeds
County
West Yorkshire
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Middle Names
Surname
Organisation
LLR Community Hospitals
House name
Riverside House
Road
Corporate Offices, Bridge Park Plaza
Locality
Bridge Park Road, Thurmaston
Town
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