CERTIFICATION / CONFIRMATION OF DEATH

VERSION No	3
REVIEWED BY	Clinical Lead (RQ)
NUMBER OF PAGES	3

Introduction

Current recommendations state that death should be verified by a doctor or other suitably qualified personnel. A nurse cannot legally certify death; this is one of the few activities that is legally required to be carried out by a registered medical practitioner. In the event of death, however, a registered nurse may confirm or verify that an expected death has occurred, providing there is an explicit local protocol in place to allow such an action (which includes guidance on when other authorities, e.g. the police or the coroner, should be informed prior to removal of the body).

Nurses undertaking this responsibility will only do so when they have received appropriate education and training and have been assessed as competent in accordance with the Nursing and Midwifery Council (NMC) code of conduct, which states that you must:

- *Have the knowledge and skills for safe and effective practice when working without direct supervision*
- *Recognise and work within the limits of your competence*
- *Keep your knowledge and skills up to date throughout your working life*
- *Take part in appropriate learning and practice activities that maintain and develop your competence and performance.*
- *In addition, also be aware of their accountability when performing this role.*

Procedure

At the time of death, the registered nurse, or appropriately-trained healthcare worker needs to record the time, who was present, the nature of the death, and details of any relevant devices (such as cardiac defibrillators), as well as their own name and contact details in the relevant documentation. If relatives have any concerns about the death these should also be documented. The examination should establish the following:

- Absence of breath sounds and chest movements for 1 minute
- Absence of heart sounds for 1 minute
- Presence of dilated pupils unresponsive to light (e.g. from a pen torch)
- Absence of breath sounds and chest movements for 1 minute.
- This should always be witnessed by a second registered nurse or trained staff member.

When death occurs inform the medical practitioner primarily responsible for that person's care. A doctor will instruct the nurse if the body is to be kept in the home or can be moved to another service provider and will issue a death certificate on a deceased individual provided that all the following criteria are met:

- The doctor was in attendance during the last illness
- The deceased was seen within 14 days prior to death
- An external examination has been made by the certifying doctor
- The cause of death is known and is natural (i.e. not due to violence, neglect, suspicious circumstances, previous occupation or related to an operative procedure).

The doctor must state the cause of death to the best of their knowledge and belief. Only the underlying cause of death should be stated, which is defined as the disease or injury that initiated the final chain of events leading to death. When recording a malignant disease, state the histology, anatomical site of primary and presence of any metastases.

1. **Unexpected Death:** If the death is unexpected (i.e. sudden) the person in charge should inform the doctor immediately. The doctor will ask questions about aspects of the illness or the care given; these should be answered appropriately. The body must not leave the premises until death is certified by a doctor.

2. **Referral to the Coroner:** A doctor may report the death to a coroner in the following circumstances:
   - Cause of death is unknown
   - Death was violent or unnatural
   - Death was sudden and unexplained
   - Deceased was not visited by a medical practitioner during their final illness
   - Medical certificate is unavailable
   - Deceased was not seen by the doctor who signed the medical certificate within 14 days prior to death or after they died
   - Death occurred during an operation or whilst still under the effects of anaesthetic
   - Medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning.

   The coroner may decide that the cause of death is clear, in which case
   - The doctor signs a medical certificate
   - The medical certificate is taken to the registrar
   - The coroner issues a certificate to the registrar stating that a post-mortem is not needed.

   a) **Post-mortems:** The coroner may decide that a post-mortem is needed to find out how the person died. This can be done either in a hospital or mortuary. The coroner's post-mortem cannot be objected to; however, if asked, the coroner must tell you (and the person's GP) when and where the examination will take place.

   b) **After the Post-mortem:** The coroner will release the body for a funeral when they have completed the post-mortem examinations and no further examinations are needed. If the body is released with no inquest then the coroner will send a form ('Pink Form — form 100B') to the registrar stating the cause of death. The coroner will also send a 'Certificate of Coroner — form Cremation 6' if the body is to be cremated.

   c) If the Coroner Decides to Hold an Inquest:
   - A coroner must hold an inquest if the cause of death is still unknown, or if the deceased either possibly died a violent or unnatural death, or died in prison or police custody.
   - The death cannot be registered until after the inquest.
   - The coroner is responsible for sending the relevant paperwork to the registrar.
   - The coroner can give an interim death certificate to prove the person is dead; this can be used by the family to let organisations know of the death and apply for probate.
   - When the inquest is over the coroner will tell the registrar what to put in the register.
   - See also the following links:
     - *Using the "Tell us Once' service: https://www.gov.uk/after-a-death/organisations-you-need-to-contact-and-tell-us-once*
     - *Applying for a grant of representation: https://www.gov.uk/wills-probate-inheritance/applying-for-a-grant-of-representation*

   d) All records must be kept for 3 years after the death.

3. **Cremation Forms**
   - The doctor will complete form B of the cremation form (the first section) if requested and need not have issued the death certificate in order to do so;
   - however, the doctor must satisfy the criteria in the section "certification of death". It is the responsibility of the doctor who completes form B
   - to contact another doctor in order to complete form C; the latter must not have known the individual and not be a partner of the hospice or doctor.
   - The completed cremation form should be left in the manager's office for collection.
   - The undertakers should be informed if the individual was fitted with a cardiac pacemaker.

4. **The suicide of an individual must be reported to the coroner.**

Notifications of a death should be made to the Care Quality Commission (CQC) within 24 hours in line with Regulation 20 and 20a of the Health and Social Care Act 2008 (Regulations 2014).

Further Guidance

What to do after someone dies: https://www.gov.uk/after-a-death/overview