Acacium Group

CLIN 27 Death of a Client and Care After Death Policy

Policy Reference | CLIN 27

Version | V2.1

Policy Name	Death of a Client and Care After Death Policy
Purpose of Document	To ensure that the correct preparation, procedure, and outcomes, are achieved by implementing a consistent and systematic approach to the procedure of last offices.
Target Audience	All workers
Version	V2.1
Author	Karen Matthews-Shard
Date of Approval	December 2012
Published Date	December 2012
Lead Director	Karen Matthews-Shard
Review Frequency	3 yearly
Last Reviewed	November 2023
Next Review Date	November 2026
Risk and Resource Implications	Risk: Care of a body after death that does not meet the spiritual needs and / or beliefs of the deceased, and their family. Resources: Training.
Associated Strategies and SOPs	CLIN 07 Infection Prevention Policy CLIN 13 Record Keeping CLIN 14 Health Records Management CLIN 22 General Care Policy CLIN 26 Clinical Governance Policy CLIN 40 Do Not Attempt Resuscitation Policy CORP 07 Equality, Diversity & Inclusion Policy GEN 16 Death of a Client/Care After Death IG 13 Collection & Recording of Client Data
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
Draft v 1	Dec 2011	First draft.	K. Matthews- Shard
Final	Dec 2011	With S James and K Matthews-Shard changes.	K. Matthews- Shard
V1.1	Dec 2012	Annual review.	Kate Nicholson-Florence
V1.1	Oct 2013	Annual review.	KNF/KMS
V1.2	Jan 2014	Proofread.	JD
V1.3	Nov 2014	Annual review.	Vikki Maiden/ KNF
V1.3	Oct 2015	Annual review.	SJ/KNF
V1.3	Nov 2016	Annual review.	KNF/SJ
V1.4	Jan 2017	Implementation of new policy template.	KNF/SJ
V1.5	Nov 2017	Annual review.	KMS/VM
V1.5	Nov 2017	Updated to include new TCS bio brand description page.	LB/MS
V1.5	Mar 2018	Updated front sheet to include new review frequency date.	KMS/MS
V1.5	May 2018	Updated CSSIW to CIW	LW
V1.6	Apr 2019	Implementation of New Policy template	CCR/KG
V1.7	Feb 2020	Update to new Policy template	CCR/CC
V1.8	Sept 2020	3 yearly review	Clinical Advisory Group
V1.9	Oct 2020	Update re Rebrand	CCR/CC
V1.10	Jan 2021	Update re Rebrand	CC
V1.11	Apr 2021	Added CHS brand	CC

V2.0	Nov 2023	Reviewed and updated. Policy name change, previously know as Death Of A Client And Last Offices Policy	Clinical Advisory Group
V2.1	Jan 2024	Rebrand	Clinical Advisory Group

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1. Introduction

1.1 Workers with clinical responsibilities are to ensure that the service user's / client's relatives are notified of the service user's / client's death immediately if they are not present at the time. The workers are to ascertain the details of any cultural / religious practices, to ensure that the service user / client is given the appropriate last offices to meet their individual spiritual beliefs and as per the care plan or in the Advance care plan/ReSPECT.

2. Definitions

2.1 Definitions relevant to this Policy are set out in Table 1.

Table 1: Definitions

Topic	Explanation
Last offices	The term last offices relates to the care given to a body after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements The Royal Marsden 10th Edition

3. Roles & Responsibilities

3.1 The overall organisational roles and responsibilities are set out in ORG1, the Policy on Policies for drafting, approval and review of policies and standard operating procedures (SOPs).

3.2 The following table outlines the responsibilities of key people involved in the care of a service user, and their family, after their death.

Table 2: Roles and responsibilities in relation to this Policy

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that this Policy is communicated to the appropriate workers, with clinical responsibility to ensure best practice.
Line Managers / appropriate others	Operationally responsible for ensuring: • compliance with this Policy within their area of responsibility • that this Policy is supported by appropriate training, policy distribution and awareness.
Individual workers	Have a responsibility to: • undertake this procedure when they have been assessed as understanding the cultural and sensitive needs and are able to provide last offices using best practice • adhere to professional codes of practice and ensure their clinical competence.

Clinical Advisory Group (CAG)	Review polices associated documents and training content for the Group. To support high clinical standards and quality improvement agendas in line with the Groups vision, strategic aims

4. Death of a Service User / Client: Best Practice

4.1 **General points**

4.1.1 The physical management of a person who has died can be a distressing and challenging experience for the family and the care workers. Before undertaking last offices, there are several other events that must take place, including confirmation of the death. See Appendix F: Death (Recognition and Certification). There are legal implications to be taken into account, such as whether a coroner is required and cultural / religious beliefs. The term 'coroner' applies to England and Northern Ireland; in Scotland it is the 'procurator fiscal' who is responsible for investigating accidental, unexpected, unexplained, sudden or suspicious deaths.

4.1.2 Performing last offices is the final demonstration of respectful, sensitive care that a worker can offer a service user / client and their family. It enables families to be aware that care and respect continues after death and also allows both the worker and family members the opportunity for closure in the relationship, which can be helpful in the bereavement process. Families may wish to spend time with their loved one after death prior to last offices being performed. In this situation, the body should be repositioned and the environment tidied, in order to allow this time to be dignified and peaceful. See Appendix D: Last Offices Procedure.

4.2 **Legal requirements**

4.2.1 If the service user / client died unexpectedly, or if the coroner is to be informed for any reason, a post-mortem examination may be required. Examples of such situations include sudden death, death after an invasive procedure, i.e. surgery or endoscopy or a client with an industrial disease, such as. mesothelioma. If unsure as to whether a post-mortem will be required, consult the medical team who can confirm whether they will issue a death certificate or whether the case needs to be referred to the coroner. If a post-mortem is required, leave all tubes, drains and lines in place and spigot (plug) any urethral catheters or cannulae. Equipment such as ventilators should not be turned off until instructed to do so.

4.3 **Religious and cultural needs**

4.3.1 If the opportunity presents itself, it is good practice to sensitively discuss and document the service user's / client's wishes prior to death. These may also be documented in the client's treatment Escalation plan/DNAR document if one is in place.

4.3.2 Practices relating to last offices may vary according to religious and cultural needs. Information regarding these variations is included in Appendix F: Procedural Guidelines for Last Offices for People of Different Religious Faiths.

4.4 **Infection control**

4.4.1 Standard precautions should be used with all service users / clients. Leakage of bodily fluids creates an infection control risk. Therefore, steps should be taken to avoid this. There are some situations which require extra caution when preparing a body for the mortuary, and a body bag or other standard precautions will need to be used in line with government requirements, for example:

- A known intravenous drug user
- Severe secondary infection

- Gangrenous limbs / infected amputation sites
- Large pressure ulcer
- Clostridium difficile, if leakage present
- Hepatitis B, C, D
- Ebola and other viral haemorrhagic fevers
- HIV / AIDS
- CJD and other transmissible spongiform.
- Other known transmissible infections/suspected pandemic deaths e.g. Covid 19

4.5 **Care Quality Commission**

4.5.1 When a service user / client dies in England, as part of 'Outcome 18 Notification of death of a person who uses the services', the death must be notified to the CQC. The notification must include the following, if applicable:

- A unique identifier or code for the person
- The date when they started using the service
- The date and time of their death
- The time the person was found
- Whether the death was expected
- Whether the person was being restrained at the time of their death or within the seven days before their death
- Whether there are concerns about the use of controlled or other drugs relating to the death
- Whether there are concerns about the use of medical devices relating to the death
- Relevant dates and circumstances, using unique identifiers and codes where relevant
- Personal details about the person (date of birth, gender, ethnicity, disabilities, religion, sexual orientation).

4.6 **Care Inspectorate**

4.6.1 When a service user / client dies unexpectedly in Scotland, immediate reporting is required. This includes reporting if:

- The person normally used a 24-hour service but was not present in that service at the time of death
- A death occurs, or was identified, when a support service, including day care and care at home, was being provided.

4.7 **RQIA**

4.7.1 For both the Nurse Agency and Domiciliary Care Licences all deaths expected or non-expected must be reported to the RQIA via the online portal. If the death is non-expected, then further details may be requested by the RQIA.

5. Training

5.1 Acacium Group will enable their workers to participate in training in the care of a deceased service user. This will be backed up in local induction programmes and/or support from palliative care teams where available. Acacium Group workers are also expected to attend regular updates. The training will be proportionate, and relevant, to the roles and responsibilities of each worker and client specific where possible.

5.2 The delivery of training is the responsibility of the Line Managers / appropriate others. It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

6. Implementation Plan

6.1 For consultation, ratification and dissemination of this Policy, see the Policy on Policies for drafting, approval and review of policies and SOPs.

6.2 This Policy will be implemented through:

- Communication of the Policy to all relevant workers
- Communication of the Policy to all stakeholders
- Raising awareness and understanding of the Policy and related processes throughout the organisation through committee meetings, Acacium Group workers' meetings, the Acacium Group 'Knowledge Room', the website and general communication through Acacium Group induction programmes and related training.

6.3 This Policy will be implemented as part of the review of governance mechanisms and policies in Acacium Group during 2011. The Clinical Director will ensure the dissemination of this Policy across the organisation.

6.4 **Audit and monitoring**

6.4.1 The Clinical Director will monitor compliance with this Policy. See also the policy author's responsibilities in Table 2 in the Policy on Policies for drafting, approval and review of policies and SOPs.

6.4.2 Processes for monitoring the effectiveness of this Policy include:

- Audit of the standard of care of a deceased client
- Audit of evidence of effective recording in records
- Appraisal and Personal Development Plans (PDPs).

6.4.3 The audit will:

- Identify areas of operation that are covered by this Policy
- Set and maintain standards by implementing new procedures, including obtaining feedback where procedures do not match the desired levels of performance
- Highlight where non-conformance to the procedures has occurred and suggest a tightening of controls, and adjustment, to related procedures
- Report the results to the Governance Committee via the Clinical Director.

7. Associated Policies / SOPs

Policies

CLIN 07 Infection Prevention Policy
CLIN 13 Record Keeping
CLIN 14 Health Records Management
CLIN 22 General Care Policy
CLIN 26 Clinical Governance Policy
CLIN 40 Do Not Attempt Resuscitation Policy
CORP 07 Equality, Diversity & Inclusion Policy
GEN 16 Death of a Client/Care After Death
IG 13 Collection & Recording of Client Data

8. References

- **Higgins, D.** (2008). *Carrying out last offices Part 1 - Preparing for the Procedure. Nursing Times* 104(37): 20-21.
- Docherty, B. (2000). *Care of the dying patient.* Professional Nurse 15 (12): 752.
- Dougherty, L., Lister, S. (2004). *The Royal Marsden Hospital Manual of Clinical Nursing Procedures. 6th edition.* Oxford: Blackwell Publishing.
- Green, J., Green, M. (2006*). Dealing with Death – A handbook of practices, procedures and law.* London: Jessica Kingsley Publishers.
- Management of dead bodies: Frequently asked questions Nov 16
- **COVID-19: guidance for care of the deceased** July 2020
- Nearney, L. (1998). *Last Offices – Part 1.* Nursing Times 94(27): Insert 1-2.
- Nearney, L. (1998). *Last Offices – Part 2*. Nursing Times 94(28): Insert 1-2.
- Nearney, L. (1998). *Last Offices – Part 3*. Nursing Times 94(29): Insert 1-2.
- Nursing and Midwifery Council, 2004. *The NMC code of professional conduct: standards for conduct, performance and ethics.* London: NMC – revised and updated 2017.
- Department of Health, 2008. *End of Life Care Strategy: promoting high quality care for all adults at the end of life.* London: HMSO.
- Care Quality Commission, *Essential standards of quality and safety.* CQC.updated 2014
- Wilkinson and Mula (2003). *Meeting other needs: Grief and bereavement.*
- Department of Health, 2007. *Consultation on Improving the Process of Death Certification.*
- Royal College for Nursing, updated 2017. *Good practice in infection prevention and control: guidance for nursing staff.* London: RCN.
- Cooke H (2000*). When Someone Dies: A Practical Guide to Holistic Care at the End of Life.* Oxford: Butterworth-Heinemann.
- v. 2: Meeting the Spiritual Needs of Patients in a Multi-cultural Society Sept 1993
- https://www.rqia.org.uk/RQIA/files/71/71c280d0-b1d0-4002-ad91-663445d1fb05.pdf
- Dying Matters First national guidance on post-death care - April 2011
- NHS End of Life Care - https://www.england.nhs.uk/eolc/
- NHS Guidance for Staff Responsible for Care after Death (last offices) Dec 2017 https://www.suddendeath.org/Gov.uk
- Marie Curie – Providing Spiritual Care - https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/individual-needs/spirituality-end-life
- NICE - End of life care for adults: service delivery Oct 2019
- NICE - Care of dying adults in the last days of life Dec 2015
- https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/10/Guidance-for-Staff-Responsible-for-Care-after-Death.pdf
- https://www.resus.org.uk/respect/respect-healthcare-professionals TfSL-Caring-for-a-child-at-end-of-life-Professionals.pdf (togetherforshortlives.org.uk)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DRA DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. This Policy is supported by legislation and national guidance as set out in the table below.

Act, policy, guidance	Explanation
The NMC code of professional conduct: standards for conduct, performance and ethics. (Nursing and Midwifery Council, revised and updated October 2018)	• 'Nurses are personally accountable for ensuring that the interests and dignity of patients are promoted and protected, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture, religious or political beliefs' • 'If care delivery is delegated to others who are not registered nurses, nurses remain accountable for the appropriateness of the delegation and ensuring that adequate support or supervision is provided'.
Human Rights Act 1998 (England, Wales, Scotland and Northern Ireland)	The Human Rights Act 1998 incorporates the European Convention on Human Rights into the legal systems of Northern Ireland, England, Wales and Scotland. It is an Act to give further effect to rights and freedoms guaranteed under the European Convention on Human Rights; to make provision with respect to holders of certain judicial offices who become judges of the European Court on Human Rights; and for connected purposes.
'Essential Standards of Quality and Safety'. (Care Quality Commission, 2010)	Regulator standards for England.
Regulation and Quality Improvement Authority (RQIA). 2003	'The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.' The reviews undertaken by the RQIA are based on the Department of Health's guidance, 'Quality standards for health and social care', published in 2006. In 2009, the duties of the Mental Health Commission were also transferred to the RQIA.
Health and Social Care Act 2008 (revised and updated 2012)	The relevant part of this Act to the Policy is the introduction of the CQC, which is an integrated regulator for health and adult social care bringing together existing health and social care regulators under one regulatory body. The CQC has new powers to ensure safe and high-quality services.
Public Health England April 2013	Public Health England is an executive agency of the Department of Health and Social Care, and a distinct organisation with operational autonomy. They provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support. Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service
Health Protection Scotland (HPS)	HPS was established by the Scottish Government in 2005 to strengthen and coordinate health protection in Scotland.
Public Health Authority Northern Ireland (PHA)	The PHA was established in 2009 under a major reform of health structures in Northern Ireland.
Birth and Death Registration Act 1953, Section 22.	All Births and Deaths are Registered

The Cremation (England and Wales) Regulations 2008 came into effect on 1January 2009. They modernised and consolidated all previous regulations, replacing the Cremation Regulations 1930	The Cremation (England and Wales) Regulations 2008 were amended in 2016 and again in 2017

2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: Last Offices Procedure

This guidance should be undertaken only after approved training and, supervised practice have taken place. - It should also be carried out in accordance with local policies and protocols and the client's care plan.

1. Equipment

- Disposable plastic aprons
- Disposable plastic gloves/Appropriate PPE in line with Government guidelines
- Bowl of warm water, soap, toiletries, face cloth, disposable wash cloths and two towels
- Service user's / client's own electric razor, comb and equipment for nail care
- Equipment for mouth care, including equipment for cleaning dentures
- Service user's / client's personal clothing, i.e. night dress, pyjamas, clothes previously requested by the client or clothes that comply with family / cultural wishes
- Gauze, waterproof tape, dressings and bandages if wounds or intravenous, arterial lines, and/or cannulae are present (If applicable)
- Disposable or washable receptacle for collecting urine if appropriate
- Plastic bags for clinical and household waste
- Sharps bin if appropriate
- Clean bed linen.

2. Last Offices Guidance

	Action	Rationale
1.	Inform the GP / medical practitioner of the service user's / client's death. **Unexpected death** If the death is unexpected, the service user / client must not be touched in any way until the coroner has been informed and the police allow the service user / client to be touched. A post-mortem may be required. Therefore, it is essential to ascertain from medical staff whether drains, IVs, syringe drivers, tracheostomy tubes. catheters etc. should be left in place. This would include leaving ventilators on. (If applicable) Anyone present at the time of death is not permitted to leave the venue. The worker must inform the on-call manager as soon as possible. A statement to the police, which is routine practice, may be required.	It is a legal requirement that only doctors can complete and issue certificates of death. The aforesaid doctor must also have attended the patient during their illness and must state to the best of his / her knowledge and belief the cause of death (Birth and Death Registration Act 1953, section 22). Wait for instruction from the GP / medical practitioner prior to the removal of any invasive lines or medical devices, e.g. a nasogastric tube/ ventilator.
2.	The relatives are likely to be present, but if this is not the case, relatives must be contacted. Offer support to relatives and / or next of kin.	To ensure relevant individuals are aware of the service user's /client's death Providing Care after Death – Marie Curie April 20

3.	If the service user / client had an infectious disease that is notifiable, it is the responsibility of the GP to inform the Public Health England. Public Health England may advise of specialist mechanisms to be undertaken if there is an infectious disease, such as HIV or CJD.	'Certain extra precautions are required when handling a service user / client who has died from an infectious disease. However, the deceased will pose no greater threat of an infectious risk than when they were alive. All workers will have practiced universal precautions when caring for the service user/client; and this practice must be continued when caring for the deceased client'. (HSE 2003)
4.	Last offices should be carried out within two to four hours of death wherever possible and in line with the clients/service users' spiritual requirements.	'Rigor mortis can occur relatively soon after death, and this time is shortened in warmer environments. (Berry and Griffie 2006)
5.	If possible, determine from the family or carers, the service user's / client's previous wishes for care after death. This may also have been detailed within a care plan	'Some families and carers may wish to assist with last offices, and within certain cultures it may be unacceptable for anyone but a family member or religious leader to wash the client' (Green and Green 2006). 'Families and carers should be supported and encouraged to participate if possible, as this may help to facilitate the grieving process' (Berry and Griffie 2006).
6.	Wash hands and put on disposable gloves and a disposable plastic apron in line with current guidelines.	'Personal protective equipment must be worn when performing last offices, and is used to both protect yourself and others from the risks of cross-infection' Providing Care after Death – Marie Curie April 20
7.	If the service user / client is on a pressure-relieving mattress or device, this must not be switched off until the service user / client is removed from the premises. Consult the manufacturer's instructions before switching off or changing settings.	'Nurses must act at all times to maintain the service user's / client's safety when using a pressure-relieving mattress or device' (RCN 2003).
8.	Lie the service user / client on his / her back, with the assistance of another person if possible. Do not attempt to close the jaw by using any type of external support ie pillows/bandages/rolled towel. Stop any infusions immediately and leave instu. Do not remove any mechanical aids, such as syringe drivers, heel pads, etc, until permission has been given to do so – this may be required from the Coroner/GP/lead clinician Straighten the service user / client's limbs where appropriate	'To maintain the service user's / client's privacy and dignity' (NMC 2008), and for future nursing care of the body. 'A body with flexed limbs can be difficult to fit easily into a mortuary trolley, mortuary fridge or coffin and can cause additional distress to any relatives who wish to view the body. However, if the body cannot be straightened, force should not be used as this can be corrected by the funeral director' (Green and Green 2006).
9.	Close the service user's / client's eyes by applying light pressure to the eyelids for 30 seconds	'To maintain the service user's dignity' (NMC 2018), and for aesthetic reasons. 'Closure of the eyelids will also provide tissue protection in case of corneal donation' (Green and Green 2006).

10.	Drain the bladder by applying firm pressure over the lower abdomen. Have a disposable or washable receptacle in place to collect urine	'Because the body can continue to excrete fluids after death' (Green and Green 2006).
11.	Leakages from the oral cavity, vagina and bowel can be contained by the use of incontinence pads. Service users / clients who continue to have leakages from their orifices after death will be placed in a body bag by the undertaker following last offices The packing of orifices can cause damage to the body and should only be done by professionals, i.e. mortuary technicians who have received specialist training.	'Leaking orifices pose a health hazard to workers coming into contact with the body' (HSE 2003; Green and Green 2006). 'Ensuring that the body is clean will demonstrate a continued respect for the service user's / client's dignity' (NMC 2008). 'The packing of orifices is considered unnecessary as it increases the rate of bacterial growth and therefore increases odour when these areas of the body are not allowed to drain naturally' (Berry and Griffie 2006).
12.	Exuding wounds or unhealed surgical scars should be covered with a clean absorbent dressing and secured with an occlusive dressing. Stitches and clips should be left intact. Stomas should be covered with a clean bag.	'The dressing will absorb any leakage from the wound site (Naylor et al. 2001). Open wounds and stomas pose a health hazard to staff coming into contact with the body' (RCN 2005).
13.	Remove drainage tubes etc, unless otherwise stated, and document actions and any tubes remaining, i.e. a central venous access device which should not be removed by the worker. Open drainage sites need to be sealed with an occlusive dressing, i.e. Tegaderm	'Open drainage sites pose a health hazard to staff coming into contact with the body' (RCN 2005). N.B: 'When a death is being referred to the Coroner or post-mortem, all lines, devices and tubes should be left in place. (Green and Green 2006).
14.	Wash the service user / client, unless requested not to do so for religious / cultural reasons or relatives preference Male service users should be shaved unless they chose to wear a beard in life If shaving a man, apply water-based emollient cream to the face	'For hygienic and aesthetic reasons. As a mark of respect and point of closure in the relationship between nurse and service user / client' (Cooke 2000). 'To prevent brown streaks on the skin' (Ashford and St. Peter's Hospitals NHS Trust 2005).
15.	It may be important to the family or carers that they assist with washing, thereby continuing to provide the care given in the period before death.	'It is an expression of respect and affection, and part of the process of adjusting to loss and expressing grief' (Berry and Griffie 2006).
16.	Clean the service user's / client's mouth using a glycerine stick / forceps and saline soaked swabs to remove debris and secretions. Clean dentures and replace them in the mouth if possible	'For hygienic and aesthetic reasons' (Cooke 2000).
17.	Remove all jewellery, unless specified by the service user / client or the family. Remove jewellery in the presence of another person. Describe the jewellery in the service user's /client's record but avoid the use of the names	'To meet with legal requirements, cultural practices and relatives' wishes' (Green and Green 2006).

	of precious metals and gems e.g.: yellow or white coloured metal. Get the description counter signed by another worker or a relative. Rings left on the body should be secured with tape, if loose.	
18.	Dress the service user / client in personal clothing as may be required for cultural or personal reasons.	'For aesthetics for family and carers viewing the body, or religious or cultural reasons, and to meet family or carer's wishes' (Green and Green 2006).
19.	Record all aspects of last offices management in the nursing notes, including who was present, and time and date of death Include if any jewellery has been removed, note the colours of the metals and gems but not the actual names.	. To ensure correct and easy identification of the body in the mortuary' (Green and Green 2006). To ensure there is an audit trail of all care given and all decisions made.
20.	Remove gloves and apron. Dispose of equipment according to Acacium Group policy and wash hands. See the Acacium Group Prevention and Control of Infection Policy.	'To minimise the risk of cross-infection and contamination' (Department of Health 2001).
21.	Arrange for removal to undertakers when the family feel ready and body allowed to be moved.	To allow timely removal in order to preserve the body

Appendix D: Procedural Guidelines for Last Offices for People of Different Religious Faiths

1 Guidelines

1.1 The following information is only guidance; individual requirements may vary even among members of the same faith. Varying degrees of adherence and orthodoxy exist within all of the world's faiths. The given religion of a client may occasionally be offered to indicate an association with particular cultural and national roots, rather than to indicate a significant degree of adherence to the tenets of a particular faith. If in doubt, consult the family members concerned.

1.2 These guidelines are to help workers provide last offices that meet the religious faith of the individual who has died and their family members. The death of a loved one is a very sensitive time and people from different religious faiths hold different views on what death means to them. For some faiths, death could be seen as a less upsetting experience because of such views as life after death. The worker will need to be sensitive to these different beliefs and offer support in a way that meets the family's needs.

1.3 Sometimes, full involvement in caring for the family member is required and on other occasions the family wishes will require the worker to step back completely.

Do not take action if you are not sure what to do!

2. Guidance Related to Specific Religions

Religion	Guidance
Baha'i Last offices usually acceptable.	• The body of the deceased should be treated with respect. Baha'i relatives may wish to say prayers for the deceased person, but normal last offices performed by the care worker are quite acceptable • Baha'i adherents may not be cremated or embalmed, nor may they be buried more than an hour's journey from the place of death. A special ring will be placed on the finger of the service user / client and should not be removed. • Baha'is have no objection to post-mortem examination and may leave their bodies to scientific research or donate organs if they wish. Further information can be obtained from the nearest Assembly of the Baha'i (see telephone directory). Alternatively, contact: National Spiritual Assembly of the Baha'i of the United Kingdom (England and Wales) 27 Rutland Gate, London SW7 1PD Tel: 020 7584 2566 Email: nsa@bahai.org.uk Website: www.bahai.org.uk **Baha'i Scotland** Spiritual Assembly of the Baha'is of Edinburgh 44 Albany Street,

	Edinburgh EH1 3QR Tel - 0131 333 2170 Email – secretary@edin-bahai.org.uk **Baha'i Northern Ireland** Baha'i Council for Northern Ireland Apt 4 2 Lower Windsor Avenue Belfast BT9 7DW Tel : 028 901 604 57 Email bcni@bahai.org.uk
Buddhism Last offices are acceptable but contact the relatives first**.**	• There is no prescribed ritual for the handling of the body of a Buddhist person, so last offices, as set out in Appendix D, are appropriate. A request may be made for a Buddhist monk or nun to be present • However, there are a number of different schools of Buddhism, so the relatives should be contacted for advice as some sects have strong views on how the body should be treated • When the service user / client dies, the relatives will normally inform the monk or nun if required. The body should not be removed for at least one hour if prayers are to be said • There are unlikely to be objections to post-mortem examination and organ donation, although some Far Eastern Buddhists may object to this. • Cremation is preferred. For further information contact: Benjamin Shapiro 37 Oakridge Towers Basingstoke Hampshire RG21 5LW Email: bodhiprem@buddhisthospice.org.uk **Scotland** Scotland's Buddhist Vihara Address: 1 Caldercuilt Road Glasgow G20 0AD Tel: 0141 237 2618/ Email: info@tsbv.org.uk Website: www.tsbv.org.uk **Northern Ireland** Potala Kadampa Buddhist Centre 265 Ormeau Rd Belfast

	BT7 3GG Tel: 028 90691829 Mobile: 0759 777 30 96 Email: info@meditationinbelfast.org
Christianity Last offices are usually acceptable.	• There are many denominations and degrees of adherence within the Christian faith. In most cases customary last offices are acceptable • Relatives may call the chaplain, minister, or priest, from their own church to either perform last rites or say prayers • Some Roman Catholic families may wish to place a rosary in the deceased service user's / client's hands and / or a crucifix at the service user's / client's head • Some orthodox families may wish to display an icon (holy picture) at either side of the service user's / client's head For further information, consult the local denominational minister or priest. Useful website: www.nhs-chaplaincy-spiritualcare.org.uk Applies to England, Wales, Scotland and Northern Ireland.
Humanism Last offices are usually acceptable.	• Humanism is an approach to life based on reason and a sense of common humanity, with recognition that moral values are founded within human nature and experience alone. Humanism is not a religion but a rationalist, non-religious approach to life. Humanism affirms that human beings have the right and responsibility to give meaning and shape to their own lives • Individuals who define themselves as 'humanists' should be involved in decisions relating to their own care before and after death. Unless advised otherwise, last offices should be given. For further information contact: British Humanist Association 39 Moreland Street London EC1V 8BB Tel: 020 7324 3060 Fax: 020 7324 3061 Email: info@humanism.org.uk Website: www.humanism.org.uk **Scotland** Humanist Society of Scotland 272 Bath Street Glasgow G2 4JR Tel: 0870 874 9002 **Northern Ireland** The Humanist Association of Northern Ireland Tel: 028 9267 7264 Email: info@humanistni.org
Hinduism Consult the wishes of the family ***before*** touching the body.	• Relatives may inform the family priest or one from the local temple. If unavailable, relatives may wish to read from the Bhagavad Gita or make a request that staff read extracts during the last offices • The family may wish to carry out or assist in last offices and may request that the client is dressed in his / her own clothes. If possible, the eldest son should be present. A Hindu may like to have leaves of the sacred tulsi plant and Ganges water placed in his / her mouth by relatives before death.

Therefore, it is imperative that relatives are warned that the service user's / client's death is imminent. Relatives of the same sex as the service user / client may wish to wash his / her body, preferably in water mixed with water from the River Ganges. If no relatives are present, care workers of the same sex as the service user / client should wear gloves and an apron, and then straighten the body and close the eyes. The body should **not** be washed. **Do not** remove sacred threads or jewellery

- The service user's / client's family may request that the service user / client be placed on the floor and they may wish to burn incense. It is advised that this is only done with a minimum of six people helping to avoid manual handling risks. If possible, a hoist may be used. A care worker is within their rights to refuse to do this on health and safety grounds. If this occurs, contact the Line Manager / appropriate other as soon as possible for advice.
- The service user / client is usually cremated as soon as possible after death. Post-mortems are viewed as disrespectful to the deceased person, and so are only carried out when strictly necessary.
- For further information, contact the nearest Hindu temple (see telephone directory) or:
- National Council of Hindu Temple (UK)
  84 Weymouth Street
  Leicester
  LE4 6FQ
  Tel: 01162661402
  Email: info@nchtuk.org

Scotland
The Hindu Temple of Scotland
Mr Jagannathan: 07795 474627 / 0141 5849962

Dr Balachandran: 07834 562980

Mr Premkumar: 07843 602134 / 01698 735137
Dr Gopinathan: 01236 760954 / 07881 880648

contactus@hindutempleofscotland.com
or
The Hindu Temple of Scotland
66 Mote Hill
Hamilton
Lanarkshire
Scotland
ML3 6EF

Northern Ireland
Belfast Radha-Krishna Temple
49 Malone Road
Belfast
BT9 6RY

Laxmi-Narayan Mandir
86 Clifton Street
Belfast
BT16 1AB

	Belfast Radha Madhava Mandir (ISKCON) 140 Upper Dunmurry Lane Belfast BT17 0HE
Jainism Last offices are usually acceptable, and relatives may wish to be present and / or assist with last offices.	• The relatives of a Jainist service user / client may wish to contact their priest to recite prayers with the service user / client and family • The family may wish to be present during the last offices and also to assist with washing. However, not all families will want to perform this task • The family may ask for the service user / client to be clothed in a plain white gown or shroud with no pattern or ornament, and then wrapped in a plain white sheet. They may provide the gown themselves • Post-mortems may be seen as disrespectful, depending on the degree of orthodoxy of the service user / client. Organ donation is acceptable • Cremation is arranged whenever possible within 24 hours of death • Orthodox Jains may have chosen the path of Saliekhana, that is, death by ritual fasting. Saliekhana is rarely practiced today although it may still have an influence on the Jain attitude to death. For further information, contact: The Institute of Jainology (Applies to England, Scotland and Northern Ireland) Unit 18 Silicon Business Centre 26 Wandsworth Road Greenford Middlesex UB6 7JZ Tel: 02089 97 2300 Fax: 02089 97 4964 Email: info@jainology.org The Jain Centre 32 Oxford Street Leicester LE1 5XU Tel: 0116 254 1150 Email: help@jaincentre.com
Jehovah's Witness Last offices are usually acceptable.	• Routine last offices are appropriate. Relatives may wish to be present during last offices, either to pray or to read from the Bible. The family will inform staff should there be any special requirements, which may vary according to the service user's / client's country of origin • Jehovah's Witnesses usually refuse post-mortems unless absolutely necessary. Organ donation may be acceptable. Further information can be obtained from the nearest Kingdom Hall (see telephone directory) or: The Medical Desk The Watch Tower Bible and Tract Society Watch Tower The Ridgeway London NW7 1RN

	Tel: 020 8906 2211 Email: his@wtbts.org.uk **Scotland** Jehovah's Witnesses Kingdom Hall of Jehovah's Witness Court St Dundee Angus DD3 7QQ Tel: 0843 258 5684 **Northern Ireland** Kingdom Hall of Jehovah's Witnesses 64a O'Byrne Road Bray Co. Wicklow Ireland Tel: 01 287 7998
Judaism Care workers are permitted to perform any procedure for preserving dignity and honor. Wearing gloves, handle the body as little as possible.	• The family will contact their own rabbi if they have one. Prayers are recited by those present • Traditionally, the body is left for about eight minutes before being moved, while a feather is placed across the lips and nose to detect any signs of breath • Usually, close relatives will straighten the body. The body should be handled as little as possible, but, wearing gloves, care workers may: ○Close the eyes ○Put the arms parallel and close to the sides of the body, leaving the hands open ○Straighten the legs ○Remove tubes unless contraindicated. • Watchers stay with the body until burial (normally completed within 24 hours of death). In the period before burial a separate non-denominational room is appreciated, where the body can be placed with its feet towards the door • It is not possible for funerals to take place on the Sabbath (between sunset on Friday and sunset on Saturday). If death occurs during the Sabbath, the body will remain with the watchers until the end of the Sabbath. Advice should be sought from the relatives. In some areas, the registrar's office will arrange to open on Sundays and Bank Holidays to allow for the registration of death where speedy burial is required for religious reasons. The Jewish Burial Society will know whether this service is offered in the local area • Post-mortems are only permitted if required by law. Organ donation is sometimes permitted. • Cremation is unlikely, but some non-orthodox Jews are now accepting this in preference to burial. For further information contact: The Burial Society of the Unite Synagogue Tel: 020 8343 6283 Email: mhartog@theus.org.uk The Office of the Chief Rabbi (Orthodox) 305 Ballards Lane

	London N12 8GB Tel: 0208 343 6301 Email: info@chiefrabbi.org Reform Synagogues of Great Britain The Sternberg Centre for Judaism 80 East End Road Finchley London N3 2SY Tel: 020 8349 5640 Union of Liberal Progressive Synagogues Montagu Centre 21 Maple Street London W1T 4BE Tel: 01582 873414 **Scotland** Giffnock Synagogue 222 Fenwick Rd Giffnock Glasgow G46 6UE Rabbi Rubin: Tel: 0141 577 8250 Newton Mearns Synagogue 14 Larchfield Court Newton Mearns Glasgow G77 5PL Rabbi Pinchas Hackenbrock: Tel : 0141 639 4000 Langside Synagogue 125 Niddrie Rd Glasgow G41 Tel: 0141 423 4062 Garnet Hill Synagogue 129Hill St off Sauchiehall St Glasgow G3 6UB Tel: 0141 332 4911 Glasgow New Synagogue/Or Hadash 147 Ayr Road Newton Mearns

	Glasgow G77 6RE Tel: 0141 639 4083 Email: shul@gns.org.uk **Northern Ireland** Office of Chief Rabbi Tel: +353 1 492 37 51 Fax: +353 1 492 46 80 Email: irishcom@iol.ie **Community Rabbi and Chabad Representative** Rabbi Zalman Lent Email: rabbilent@jewishireland.org **Cantor** Alwyn Shulman Tel: 0863 62 5651
Mormom Church of Jesus Christ of the Latter Day Saints Last offices are usually acceptable. Relatives may wish to be present.	• There are no special requirements, but relatives may wish to be present during last offices. Relatives will advise care workers if the service user/client wears a one or two piece sacred undergarment. If this is the case, relatives will dress the service user / client in these garments. For further information, contact the nearest Church of Jesus Christ of Latter Day Saints (see telephone directory) or: The Church of Jesus Christ of Latter Day Saints 751 Warwick Road Solihull West Midlands B91 3DQ Tel: 0121 712 1161 Useful website: www.ldschurch.org **Scotland** The Church of Jesus Christ of Latter Day Saints Scotland Edinburgh Mission 51 Spylaw Road Edinburgh Scotland EH10 5BP Tel: 0131 337 1283 Fax: 0131 313 1282 **Northern Ireland** The Church of Jesus Christ of Latter Day Saints 20 Circular Road Coleraine BT52 1PS Tel: 02870 321214 Website: www.lds.org 403 Holywood Road Belfast

	BT4 2GU Tel: 028 90768250 Website: www.lds.org
Muslim (Islam) Do not touch the body without gloves. Do ***not*** wash the body or cut the nails.	Where possible, the service user's / client's bed should be turned so that their body (head first) is facing Mecca. If the service user's / client's bed cannot be moved, then the service user / client can be turned on to their right side so that the deceased's face is facing towards Mecca • Many Muslims object to the body being touched by someone of a different faith or opposite sex. If no family members are present, wear gloves and close the service user's / client's eyes and straighten the body. The head should be turned to the right shoulder and the body covered with a plain white sheet. The body should not be washed, nor the nails cut. • The service user's / client's body is normally taken to a mosque as soon as possible to be washed by another Muslim of the same sex or may be washed at home. Burial takes place preferably within 24 hours of death. Cremation is forbidden. Post-mortems are permitted only if required by law. Organ donation is not always encouraged, although in the UK a Fatwa (religious verdict) was given by the UK Muslim Law Council which now encourages Muslims to donate organs. For further information contact: **IQRA Trust** The Bordesley Centre Stratford Road Sparkhill Birmingham B11 1AR Tel: 0121 753 0297 **Scotland** Muslim Council of Scotland 27 Arlington Street Glasgow G3 6DT Tel: 0141 574 4300/0799 933 3850 Email: info@mcscotland.org Website: www.mcscotland.org **Northern Ireland** Northern Ireland Muslim Family Association 7 Rugby Road Belfast BT7 1PS Tel: 02890 315784
Rastafarian Last offices are usually acceptable.	Customary last offices are appropriate, although the service user's / client's family may wish to be present during the preparation of the body to say prayers. • Permission for organ donation is unlikely and post-mortems will be refused unless absolutely necessary Useful websites: www.rastafarian.com

	www.bbc.co.uk/religion/religions/rastafari/ Applies to England, Scotland and Northern Ireland.

Sikhism
Usually the family takes responsibility for last offices.
	• Family members (especially the eldest son) and friends will be present if they are able
	
	• Usually, the family takes responsibility for the last offices, but care workers may be asked to close the service user's / client's eyes, straighten the body and wrap it in a plain white sheet
	• Do not remove the '5 ks', which are personal objects sacred to the Sikhs:
	
	  ○ Kesh: Do not cut hair or beard or remove turban.
	  ○ Kanga: Do not remove the semi-circular comb, which fixes the uncut hair.
	  ○ Kara: Do not remove bracelet worn on the wrist.
	  ○ Kaccha: Do not remove the special shorts worn as underwear.
	  ○ Kirpan: Do not remove the sword: usually a miniature sword is worn.
	• The family will wash and dress the deceased person's body
	• Post-mortems are only permitted if required by law. Sikhs are always cremated
	• Organ donation is permitted but some Sikhs refuse this as they do not wish the body to be mutilated.
	
	For further information, contact the nearest Sikh temple of Gurdwara (see telephone directory). Alternatively, contact:
	Sikh Missionary Society UK
	10 Featherstone Road
	Southall
	Middlesex
	UB2 5AA
	Tel: 020 8574 1902
	Fax: 02085 741912
	Email: info@sikhmissionarysociety.org
	Website: www.sikhmissionarysociety.org
	
	Scotland
	Bagh Singh: 07958 620744
	Suki Singh Pooni: 07970 847066
	Siddharth Singh: 07828 636099
	Manpreet Kaur: 07543 634785
	Email: info@aberdeensikhsangat.com
	
	Northern Ireland
	Irish Sikh Council
	2 Tullyhall Court
	Lucan
	Co. Dublin
	Republic of Ireland
	Phone: +353 (01) 437 0950/0872 605 410 / 0857 29 445
	Email: info@irishsikhcouncil.com

Zoroastrian (Parsee) Last offices **not** acceptable.	• Customary last offices are often unacceptable to Zoroastrian service users / clients • The family may wish to participate in the preparation of the body • Orthodox Parsees require a priest to be present, if possible

	• After washing, the body is dressed in the Sadra (white cotton or muslin shirt symbolising purity) and Kusti (girdle woven of 72 strands of lambs' wool symbolising the 72 chapters of the Yasna [Liturgy]) • Relatives may cover the service user's / client's head with a white cap or scarf • It is important that the funeral takes place as soon as possible after death • Burial and cremation are acceptable. Post-mortems are forbidden unless required by law • Organ donation is forbidden by religious law. For further information contact: The Zoroastrian Trust Funds of Europe 440 Alexandra Avenue Harrow Middlesex HA2 9TL Tel: 020 8866 0765 Email: secretary@ztfe.com Useful website: http://www.bbc.co.uk/religion/religions/zoroastrian/ Applies to England, Scotland and Northern Ireland.

Appendix E: Death (Recognition and Certification)

1. Recognition of Death

1.1 It is vital when certifying death to ensure that death has indeed occurred. In the UK, at present, there is no legal definition of death, although guidelines do exist for the diagnosis of death in more complex situations. There has been recent guidance on the diagnosis and confirmation of death from the Academy of Medical Royal Colleges. The guidance is mainly concerned with confirmation of death in hospital and in circumstances where the diagnosis of death may be more difficult (for example, brain stem death patients on ventilators).

1.2 **New guidance on confirmation of death**

Proceed without unnecessary and distressing delay. Death may be obvious with clear signs pathognomonic of death (hypostasis, rigor mortis). If not obvious, death should be identified by 'the simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation'. The new guidance in addition requires that:

- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made (for example body temperature, endocrine, metabolic and biochemical abnormalities more relevant in hospital) where a DNAR or equivelent does not prohibit it.
- One of the following is fulfilled:
    - The individual meets the criteria for not attempting cardiopulmonary resuscitation
    - Attempts at cardiopulmonary resuscitation where appropriate, have failed
    - Treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient, not in his / her best interest to continue and / or is in respect of the patient's wishes in an advance directive.
- The individual should be observed by the person responsible for confirming death for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred.
- In primary care, the absence of mechanical cardiac function is normally confirmed using a combination of the following:
    - Absence of a central pulse on palpation
    - Absence of heart sounds on auscultation

In hospital this can be supplemented by one or more of the following:

- Asystole on a continuous ECG display
- Absence of pulsatile flow using direct intra-arterial pressure monitoring
- Absence of contractile activity using echocardiography.

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest
- After five minutes of continued cardiorespiratory arrest, the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed

- The time of death is recorded as the time at which these criteria are fulfilled.

1.3 **The current recommendations state that:**

"Death should be verified by a doctor, or other suitably qualified personnel."

Deaths are increasingly occurring in patient's own homes, as improved community nursing provision enables dying patients to remain out of hospital. The precise moment of death may be difficult to recognise and, for a period of time after respiration has ceased and the heart has stopped, the patient may still potentially be resuscitated.

In certain conditions a patient may appear dead if not thoroughly examined:

- Following prolonged submersion in cold water
- Following ingestion of alcohol or drugs
- When hypoglycaemic or in a coma.

They may recover completely, if treated appropriately. It should be remembered that hypothermia protects against hypoxic neurological damage, and that children under the age of five are more resilient to hypoxic brain injury. Therefore, resuscitation should be continued in these circumstances until normal body temperature is reached, even if the patient appears to be dead.

1.4 **Examination**

A thorough physical examination should be carried out to ascertain whether or not death has taken place. First inspection should reveal a deathly pallor (particularly of the face and lips), and relaxation of the facial muscles. This leads to drooping of the lower jaw and open staring eyes. Further examination may include:

- Palpation of all major pulses.
- Auscultation of the heart and lungs for at least one minute, and repeated at intervals over at least five minutes.
- Inspection of the eyes for fixed dilated pupils, absence of corneal reflexes, cloudiness of the cornea and loss of eye tension.
- Examination of the fundi for segmentation of retinal blood columns 'boxcars' (only present in 30%).
- Examination of the trunk may show evidence of post-mortem staining as a result of hypostasis.
- Examination of muscle tone for rigor mortis (begins approximately three hours after death).
- Decreased temperature - will depend on ambient temperature, but may not occur for up to eight hours.

1.5 **Practical definition of death in primary care**

For practical purposes in general practice, death may be deemed to exist in an unresponsive patient, with a body temperature over 35°C, who has not been taking drugs or alcohol if:

- There are no spontaneous movements
- There is no respiratory effort (examine for one minute)
- There are no heart sounds or palpable pulses (examine for one minute)
- There is an absence of reflexes, e.g. corneal
- The pupils are fixed and dilated.

1.6 **Certification of death**

Management of a death will depend on:

- The circumstances of the death
- Where it has occurred
- Whether or not it was anticipated

- Whether or not there is any suspicion of foul play.

Relatives and / or friends of the deceased may be very distressed and GPs attending a death should offer support, where appropriate. Bereaved families may also require guidance on the procedures following a death, particularly if the death was unexpected. Verification of death may be performed by any appropriately qualified person.

1.7 **Death certificate**

A death certificate may be issued by a doctor who has provided care during the last illness and who has seen the deceased within 14 days of death (28 days in Northern Ireland) or after death. They should be confident about the cause of death. The death certificate is given to the next of kin, who is required to deliver it to the Registrar of Births, Deaths and Marriages within five days. In the absence of a next of kin, the Births and Deaths Registration Act 1953 specifies who else can do this:

- Any relative of the deceased person present at the death or in attendance during his/her last illness
- Any other relative of the deceased residing or being in the sub–district where the death occurred
- Any person present at the death
- The occupier of the house if he / she knew of the happening of the death
- Any inmate of the house who knew of the happening of the death
- The person causing the disposal of the body

If the registrar decides that the death does not need reporting to the coroner, he will issue:

- A certificate for burial or cremation
- A certificate of registration of death (for social security purposes)
- Copies of the death register (on request; at least two copies advisable as banks and insurance companies expect to see them).

If the body is to be buried in England, there are no further formalities. If the burial is to be outside of England, an 'Out of England Order' is needed from the Coroner. If the burial is to be at sea, an 'Out of England Order' and a license from the Ministry of Agriculture, Fisheries and Food (MFFA) is needed, and the District Inspector of Fisheries should be notified.

1.8 **Cremation certificate and forms**

New regulations and new cremation forms were introduced in January 2009.

There are very few policy changes which require different procedures. The only significant one is that applicants now have the right to inspect the medical forms ('Cremation 4' and 'Cremation 5') before the medical referee authorises the cremation. It is expected that numbers of applicants wishing to exercise this right will be low. Where a post-mortem examination is requested by the medical referee, the applicant should, on request, be able to have a copy of the post-mortem examination report.

This certificate is usually given to the undertaker who takes it to the medical referee at the crematorium, who checks the forms and gives the final approval necessary for cremation to occur. Occasionally, circumstances occur in which the death must be reported to the coroner or procurator (Scotland) rather than issuing a death certificate. Legally, this is the responsibility of the registrar, but it is good practice (and saves time and distress for relatives) for doctors to report directly to the coroner or procurator if no doctor satisfies the attendance requirements for being able to certify death, e.g. the only doctor who has provided care during the last illness is away on holiday, then the death must be reported to the coroner / procurator. Other examples which require reporting include:

- Identity of deceased unknown
- If the cause of the death is unknown
- Sudden, unexpected, suspicious, violent (homicide, suicide, accidental) or unnatural deaths
- Deaths due to alcohol or drugs
- Doubtful stillbirth
- Deaths related to surgery or anaesthetic
- Deaths within 24 hours of admission to hospital
- Deaths in prison.

In some cases, a death certificate may be issued, but ticking a box on the reverse of the death certificate will alert the coroner or other agencies that further action may be required. Deaths which may require this include:

- Death from an industrial disease, poisoning or accident
- Death of a patient in receipt of an industrial or war pension
- Death by suicide, poisoning or drugs
- Death as a result of an illegal abortion
- Death from neglect, want or exposure.

2. Document references

- Academy of medical Royal Colleges, 2008*. A Code of Practice for the Diagnosis and Confirmation of Death*.
- Ministry of Justice, 2008. *The Cremation (England and Wales) Regulations 2008: Guidance for cremation authorities and crematorium managers.*
- BJA – Diagnosis of Death June 2011
- RCGP - Standard 7: Care after death
- Regional Infection Prevention and Control Manual for Northern Ireland