VERIFICATION (CONFIRMATION) OF EXPECTED DEATH POLICY

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VERIFICATION (CONFIRMATION) OF EXPECTED DEATH POLICY

Statement

A nurse cannot legally certify death - this is one of the few activities required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may confirm or verify 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 must only do so providing they have received appropriate education and training and have been assessed as competent.


Aims

On completion of the training, the Advanced Nurse Practitioner (ANP) will demonstrate competence in verification of an expected death of an adult in the patient's own home or in a Residential/Nursing home setting. The ANP will have the knowledge and skills for safe and effective practice when working without direct supervision in the verifying death recognising, and working within the limits of professional competence.

Objectives

To enable the Advanced Nurse Practitioner to:

- Explain the difference between an expected and unexpected death
- Explain the procedure for verifying expected death
- Demonstrate an awareness of personal accountability regarding this role expansion
- Explain what is/ might constitute un-natural death
- Identify deaths that need reporting to the Coroner/ Police
- Accurately state what information should be included in the records/documentation

The role of the ANP in relation to professional practice and verification of expected death

Practitioners have a responsibility to deliver care to an acceptable professional standard. This goes beyond the practical skill required to perform a task, and encompasses the knowledge that underpins evidence based nursing practice.

The code of Professional Conduct (NMC, 2004,2008) makes clear that practitioners must acknowledge any limitations in their knowledge and competence and decline any duties or responsibilities unless able to perform them in a competent manner.
The challenge of the health professional taking on the skill of verification of expected death is to identify if the death is indeed expected and if not utilise the necessary reporting procedures. The opportunity to practice the skill to maintain standards of competency is essential together with the opportunity to re-evaluate at regular intervals that the level of competency has been maintained.

The opportunity to review competency can be taken up via regular clinical supervision or at annual personal development reviews. (Knowledge and Skills Framework developmental review. NMC 2004,2008 & NHS Scotland 2004).

**Accountability**

Practitioners are individually accountable for the health care they provide. The use of Professional knowledge, judgement and skills to make a decision should enable the professional to account for the decision made (Dimond 2005) which is a key element of accountability.

Nurses have a legal and professional duty to care for patients. In law the courts could find the Nurse negligent if he/she failed to provide proper care. When undertaking verification of death, nurses have a professional responsibility to act in the best interest of the patient and follow evidence based practice, (Rowe 2000) as well as ensuring contemporaneous documentation is accurate (NMC 2007).

**References:**

- Nursing and Midwifery Council (2008a) Advice on Delegation for Registered Nurses and Midwives. NMC, London

**Training Package**

**Reading List**


Confirmation (verification) of death, Nursing and Midwifery Council (2002)


Home Office. Report of the Committee of Death Certification and Coroners, CMND 4810. (November 1971 (Para 5.01)


Phair L “Death duties: a responsibility too far?” in Nursing Older People, 2002 Jul-Aug; 14 (5): 32-33

RCN Confirmation (verification) of expected deaths by registered nurses (2004) www.rcn.org.uk

Report of the Committee on Death Certification and Coroners, Home Office CMND 4810. November 1971.) (Para. 5.01)

Royal College of Nursing (RCN) (1996) Verification of Death by Registered Nurses Issues in Nursing and Health, number 38


Websites of interest:

http://www.coroner.org.uk

Training Information

Verification of the death in the community

As an ANP it is expected to deal with dying patients where it would be inappropriate to routinely commence resuscitation, unless the death was unexpected death or as a result of sudden collapse where immediate referral to emergency ambulance service would be necessary.
The legal position at present is that ‘a registered medical practitioner, who has attended a deceased person during his last illness, is required to give a medical certificate of the cause of death’ to the best of his knowledge and belief’, and to deliver that certificate forthwith to the Registrar’. This certificate requires that the doctor state the last date in which he saw the deceased person alive, and whether or not he saw the body after death. Doctors are not obliged to view the body, but good practice requires that if he has any doubt about the fact of death, he should satisfy himself in this way’ (paragraph 5.01 report of the committee on death, certification and coroners. Home Office 1971)

**Verifying the Death**

Verifying the fact of death is the physiological assessment of a patient who has ceased to live and this does not legally have to be carried out by a doctor. Verification of death is increasingly being undertaken by nurses, paramedics, emergency care practitioners and police officers. Following verification of a death, by law a medical doctor is required to certify death and produce a ‘medical certificate of the cause of death’, which includes stating the last date on which they saw the deceased alive and whether they saw the body after death. Registered nurses can therefore only verify and NOT certify a death.

An expected death can be defined as ‘a death where a patient’s demise is anticipated in the near future and a Registered Medical Practitioner (usually patients own GP) has seen the patient within the last fourteen days” (Report of the Committee on Death and Coroners, Home Office (1971)

To undertake verification of death each nurse will need to be aware of their professional responsibilities, the correct physical examination of the deceased, the reporting processes used in the locality they work, the role of the Coroner’s Office, legal aspects of death and certification.

**Expected death or unexpected death?**

As an ANP you will only be expected to routinely verify expected deaths. This means that you must consider the question “how will I know if the death of my patient is expected?” It is important that you can clearly provide evidence in case you are asked by a coroner how you established this fact. Examples of evidence could be:

- Not for resuscitation in Special Patient notes
- End of Life care plan such as Liverpool Care Pathway or Preferred Place of Care Documentation
- Patient records contain information such as:
  - discussions held between patient / family and GP that clearly demonstrate terminal care
  - entries by patients’ GP or District Nurse (DN) which state end of life care and wishes

If there is no documentation already available, ensure documentation of the rational why this is an expected death, If in doubt, discuss with Medical colleague or the Hospice.
Declaration of Death

Verifying a death involves the declaration (fact) that death has taken place and this is done by checking for the following:

- Absence of Central Nervous System (CNS) activity – unresponsive to light or painful stimuli
- Absence of Respiratory activity for 120 seconds – observing the chest and listening for chest sounds with stethoscope
- Absence of Cardiac output (Apex beat for 120 seconds) – palpation of the carotid pulse and listening for heart sounds using a stethoscope

When verifying a death it is important to remember the whole person. If a patient has a head and neck cancer then finding the carotid pulse may be difficult due to past surgery, scar tissue or neck wounds.

In these circumstances another pulse point should be used but remember to document where and why as this is a variance to recommended practice and ensures there is no doubt regarding the actions. If a person is obese the heart sounds may be difficult to hear so extra care is needed.

The first clinical check carried out where there is no evidence of life is considered to be the time of death; therefore when repeating the clinical check record the first time when there was absence of CNS, respiratory and cardiac output. When verifying an expected death, there is no need to rush; take time to care for the family.

Following the verification of a deceased patient, their GP will need to certify the death. Therefore communication with the GP is paramount.

N.B. MEDICATION. Please be aware that some medicines such as high dose opiates, adrenalin and eye-drops may alter the findings on physical examination. If there is any doubt, the ANP must NOT verify the fact of death but must consult a medical practitioner without delay and document actions.

Documentation

It is important that the events surrounding the death are accurately recorded to ensure vital information is available at a later date if required. The following should be done:

- Communication – it is important to document information and advice given to the family as well as other professionals in the GP record and in any patient held records at the home
- Chronological order – it is important in all documentation to record things down as they happen, include the date and time
- Date and time of death – before or after midnight - this could make a difference to an insurance policy
- Witnesses – you should record all other persons present or involved at the time of death and their role or relationship to the patient e.g. escort, family, HCA, neighbour. If no one present then you need to say so.
- Sign and print your name clearly in any patient held records, it’s your duty to ensure others can identify who provided which care
- Document anything that could be suspicious e.g. syringe driver empty before time
Never hide anything and do not try and protect anyone or destroy evidence. If you suspect suicide then say so

**Communication in care of the dying**

Effective communication is central to good quality patient care. In palliative care the challenges are even greater than usual because there is an expectation that health care professionals will be able to discuss and cope with death in a sensitive and supportive manner. Providing end of life care will mean that you will need to handle difficult questions and be able to break bad news sensitively. To do this well you will need to develop the necessary knowledge and skills to be able to tailor the information you provide in a way that meets the needs of both patients and their families. People respond differently at the time of death and the psychological sequel of giving bad news in an abrupt and insensitive way can be devastating and long lasting.


**What happens after death?**

It is important that as a nurse you are aware of the importance of understanding the procedures for registering a death and what happens if a doctor cannot certify a death. All deaths whether natural or unnatural will follow a predetermined sequence of events. Table one is a simple illustration of the procedures as they happen after a patient death.

Most deaths we deal with in Out of Hours are patients at the end of their life and will be from natural causes and usual processes and family customs can be met and carried out as arrangements are made for disposal of the body.

Nurses do also need to remember that a small number of deaths may be as a result of unnatural causes and that when verifying death must act accordingly if they feel a death was not due to natural causes. Examples might be:

- A patient has died immediately following a fall
- A patient has died following a medication error
- Family are indicating they have purposefully given the patient too much medication
- Patient may have taken an overdose

**What should you do if you suspect that the death may be due to unnatural causes?**

Handling these situations will take tact and diplomacy as you should not try to determine the cause of death. This is for the police and coroner. What you need to do is;

- Risk assess the situation
- Protect yourself and others
- Check the patient
- Preserve the scene and call the police and wait for them to arrive
Always be tactful and sympathetic with family and relatives
Make detailed notes of events, who present, anyone who has left, what happened etc.
Inform the coordinator

Once they arrive the police will take responsibility and carry out an investigation on behalf of the coroner. The police will inform the coroners of all sudden or suspicious death they attend. On completion of their investigation they will supply the coroner or procurator fiscal with a sudden death report. If the police suspect a crime has been committed they will act in accordance with the law.

You should not be concerned about ringing the police if you have any doubts they are trained to deal with inquiries and will provide you will good advice.

If the family express concerns over the cause of death when they are registering the death the registrar can and will inform the coroner. The police may be instructed to undertake a sudden death investigation and produce a report.

**Coroner’s Information**

**History of the Coroners Service**

The duties of the early Coroner were varied and included the investigation of aspects of medieval life that had the potential benefit of revenue for the crown. Suicides were investigated on the grounds that the goods and chattels of those found guilty of the crime ‘felo de se’ or ‘self murder’ would then be forfeit to the crown, as were wrecks of sea, fires and buried treasures. Treasure Trove still remains one of the Coroners’ duties today. Sudden death in the community has always been considered an important issue since the early days and was always investigated by the Coroners; although for reasons far different from those of today. After the Norman Conquest, to deter the local communities from the habit of killing Normans, a heavy fine was levied on any village where a dead body was discovered, on the assumption that it was presumed to be Norman, unless it could be proved to be English. The fine was known as ‘Murdum’ from which the word ‘murder’ is derived.

The Coroners system continued to develop and adapt over the centuries but in the nineteenth century major changes relating to the investigation of death in the community occurred. In 1836 the first Births and Deaths Registration Act was passed. In 1887 the Coroners Act made significant changes; coroners became more concerned with determining the circumstances and the actual medical causes of sudden death, violent and unnatural deaths for the benefit of the community as a whole.

**Reporting a Death to the Coroner**

Under the Coroners Act 1988 (c13) the following deaths should be reported to the Coroner:
- When the death is sudden, unexplained, uncertified by a medical practitioner or is surrounded by suspicious circumstances
- When the death may be due to an industrial injury or disease, or to accident, violence, neglect, abortion or poisoning
- When death occurred during an operation or before recovery from the effect of anaesthetic
- When the deceased has not been treated by a doctor during their illness
- When the doctor attending the deceased did not see them within 14 days before or after death
- When death occurred in police custody or in prison

Examples in practice:
- Someone is dying of cancer, they fall out of bed and sustain a fractured (#) neck of femur and are transferred to hospital. Patient returns home and dies – this is a Coroner’s inquest
- If someone is home ‘on licence’ from prison and dies this is a Coroner’s inquest
- If a patient sectioned under the ‘Mental Health Act’ dies this is also a Coroner’s inquest

A death occurring in any of the above circumstances could well be expected by the doctor but he will still be required to report and discuss with the Coroner before issuing a death certificate. The coroner will decide if further investigation is needed.

In the case of sudden or accidental death, this is commonly done by the police who are called to the death in the community and doctors if it occurs in hospital.

Doctors also report unexpected deaths in patients they have been treating.

Registrars also report deaths to the Coroner, as well as potentially suspicious comments made by the families who are concerned or query the cause of death.

All practitioners, not just those who verify death have a duty to ensure that they address and report any concerns or suspicions they have regarding a potentially unnatural death to the Coroner.

Once a death has been reported to the Coroner, the Registrar cannot register the death and the family cannot hold a funeral until the Coroners inquiries are complete. These enquiries can take some time and relatives need to be aware of this as they will need to contact the Coroners’ office before making funeral arrangements.

**Role of the Coroner**

Coroners usually have a medical and /or legal background and are officers appointed by the council to investigate any sudden or unexplained deaths. Most have a team of people supporting them. They are independent of both local and central government and are required to act in accordance with the home office rules and procedures.

The Coroner will investigate all deaths reported and establish the facts surrounding the death to see if the death was due to natural causes and that there is a medical practitioner who is able to issue a Medical Certificate of the Cause of Death. If the Coroner is unable to establish these facts s/he will make arrangements for the body to be transported to the local hospital, where by law, a post-mortem examination will be performed.

If the Coroner wants a post mortem s/he will organise one, especially if the body is to be cremated as the Coroner cannot examine ashes. The Coroner can and does dig up the dead. It is therefore important not to mislead people and be honest when a death needs to be reported.
If the post mortem shows that death was due to natural causes then no inquest will be needed and the Coroner issues a document that allows the death to be registered and the funeral held.

If the death is not due to natural causes then the coroner is obliged to hold an inquest (Coroner Court). The Coroner will often allow a funeral to be held once the post mortem has been carried out.

**Religion**

Some ethnic groups such as Muslim’s have a need for a quick burial as they believe that pain is felt until the funeral has taken place which makes communication essential.

The Coroner will take advice from religious leader (when necessary) but still has overall control of the body and can prevent a funeral taking place.

**Coroners Court**

A Coroners Court is made up of judicial officers that are responsible for investigating violent, unnatural or sudden deaths where the cause of death is unknown. In some cases the coroner will head this court on their own. The inquest is a medical and legal enquiry into the death of the deceased. It is not a trial. The purpose of the inquest is to establish the identity of the deceased, when where and how the death occurred to determine whether further criminal investigation is necessary and to establish the facts required by the registrar. If the Coroner suspects murder or manslaughter or infanticide, then s/he must summon a jury. A Coroner’s inquest does not apportion blame on any individual but does work closely with the police.

In Scotland, the Procurator Fiscal and the Sheriff Courts investigate suspicious deaths under the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976. The Coroner can open and adjourn an inquest and issue a form to allow the funeral to take place.

An inquest adjourned will be re-opened at a later date to determine the circumstances surrounding the death. This may involve witnesses being called, who are legally obliged to attend and may be penalised if they fail to do so.

All inquests must be held in public and a member of the press is usually present, but they do not always report the case.

Once an inquest has been held the Coroner will send a report to the registrar in the district where the death occurred and the registrar will then register the death. In these circumstances family do not have to be present when the registrar registers the death as the Coroner informs them of the name and address of the person who should be notified that the death has been registered. Where there is a delay between death and the holding of the inquest it is possible for the coroner to issue an interim certificate on request to enable relatives to manage the deceased estate.
**Possible verdicts from a Coroner’s Court:**

<table>
<thead>
<tr>
<th>Verdict</th>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Killed lawfully</td>
<td>Death from industrial diseases</td>
</tr>
<tr>
<td>Killed unlawfully</td>
<td>Death by accident (inc misadventure)</td>
</tr>
<tr>
<td>Suicide</td>
<td>Stillborn</td>
</tr>
<tr>
<td>Attempted or self induced abortion</td>
<td>Death from natural causes</td>
</tr>
<tr>
<td>Dependence on drugs</td>
<td>Open verdict</td>
</tr>
<tr>
<td>Want of attention at birth</td>
<td>All other verdicts</td>
</tr>
<tr>
<td>Cause of death aggravated by lack of care or self neglect</td>
<td></td>
</tr>
</tbody>
</table>

**Summary**

An ANP should NOT verify a death if they have any doubts or when there is deviation from this Verification of Expected Death (VOED) Policy.