East Midlands Ambulance Service NHS Trust

DIAGNOSIS OF DEATH PROCEDURE

Links

The following documents are closely associated with this procedure:

- Policy for the Implementation of JRCALC Guidelines
- End of Life Care Policy
- Resuscitation Policy
- Safeguarding Children and Young People Policy & Procedure
- Safeguarding Vulnerable Adults Policy & Procedure
- Infection Prevention & Control Operational Procedure
- Resuscitation Decisions in End of Life Care Standard Operating Procedure
- Decisions relating to cardiopulmonary resuscitation – Guidance from the BMA, RCUK and RCN (3rd Ed, 2016)
- (NASMeD) Adult Cardiac Arrest best practice statement - 2016

Document Owner :	Medical Director
Document Lead:	Deputy Clinical Director
Document Type:	Procedure
For use by:	Ambulance Clinicians and EOC Staff

Equality Impact Assessment	October 2015

This document has been published on the:	
Name	**Date**
Library (EMAS Public Drive)	11 January 2019
Intranet	11 January 2019

Version Control	**Document Location** If using a printed version of this document ensure it is the latest published version. The latest version can be found on the Trust's Intranet site.

Version	Date Approved	Publication Date	Approved By	Summary of Changes
1.0	24/07/2006	July 2006	Clinical Innovation & Development Committee	New Procedure for EMAS
1.1	01/08/2007	August 2007	Clinical Governance Committee	Work required next review in six months
2.0	06/02/2008	February 2008	Clinical Governance Committee	Work completed with Coroners
3.0	01/10/2008	October 2008	Clinical Governance Committee	Review & changes from the NHSLA assessment incorporated
3.1	04/08/2009	August 2009	Medical Director (at coroners request)	Change to procedure in Leicester at Coroners request
3.2	07/08/2009	August 2009	Governance Committee	Review date amended to reflect the move to a 2 year review cycle
4.0	19/01/2010	January 2010	Clinical Governance Group	Confirmation of procedure in Lincolnshire
5.0	14/08/2012	August 2012	Clinical Governance Group	• Update all divisions coroner reporting processes • Review diagnosis of death form with coroners • Review skill section for diagnosis of death and add AECS • Remove End of Life Care Procedure
6.0	21/10/2015	14 December 2016	Clinical Governance Group	Complete review and update with emphasis on key aspects of the procedure.
6.1	01/02/2016	01/02/816	Chair of Clinical Governance Group via Urgent Approval Process	Minor typographical amendments Clarification of undertaking resuscitation of an asystolic patient Clarification around the use of undertakers within the

				Lincolnshire area Clarification around diagnosis of death documentation when at hospital Addition of traumatic arrest considerations as part of the diagnosis of death flowchart Addition of a paediatric Diagnosis of Death Flow Chart
6.2	12/02/2016	15/02/16	Document Owner	Additional email included for North Derbyshire; change reported to Clinical Governance Group on 16 March 2016.
6.3	15/02/2017	16 February 2017	Clinical Governance Group	Additional clarity around futile resuscitation
6.4	17 May 2017	30 May 2017	Clinical Governance Group	Sections 4.12 removal of 'or handed to the attending police officer'. 'Diagnosis of death forms should not be handed to police officers on scene'. 5.5 deletion of emails for Lincolnshire Central and Lincolnshire South. Lincolnshire coroners added with email address coronersofficers@lincolnshire.gcsx.gov.uk Appendix 5 Lincolnshire column 3 'handed to the attending police officer ' has been removed and replaced with 'diagnosis of death forms should not be handed to police officers on scene'.
6.5	20 September 2017	24 October 2017	Clinical Governance Group	Three month extension approved until end of January 2018
7.0	16 March 2018	10 May 2018	Clinical Governance Group	Full procedure review Updated titles Updated cardiac arrest best practice statements (2017)
7.1	21 November 2018	11 January 2019	Clinical Governance Group	One month extension approved until end of December 2018.
8.0	19 December 2018	11 January 2019	Clinical Governance Group	Full procedure review Updated titles

				Updated 'Reporting the Fact of Death Procedure for Lincolnshire's Coroner

Contents **Page**

1. Introduction

1.1. This procedure will be used by staff with HCPC or NMC registration and qualified Associate Ambulance Practitioners [AAP] (Ambulance Technicians). In addition, the identification of patients with conditions unequivocally associated with Death can be undertaken by Emergency Care Assistants and Trainee Associate Ambulance Practitioners.

1.2. Please refer to the appendices for local variations on the reporting methodology which varies between Counties. For the remainder of this procedure wherever it states Ambulance Technician/AAP it refers to those staff who have undertaken designated period of consolidated practice following the completion of their foundation course and have been signed as competent for all modules.

1.3. Special note regarding Paediatrics Cases - The Ambulance Service is tasked with conveying all children who have an unexpected death in the community to an agreed location (usually the Emergency Department) where the paediatricians will assess if there are suspicious circumstances around the death.

1.4. Specific considerations around the Diagnosis of Death in paediatric cases can be reviewed at appendix 3.

1.5. Two important points are that a child is defined as under 18, and that if the police declare the place where the death occurred a crime scene then we may be asked to return to the scene to transport the body once initial forensic scene examination is complete.

1.6. Extensive international research into resuscitation in cardiac arrest has shown that specific groups of patients have been identified in whom commencing or continuing resuscitation has no proven benefit.

1.7. Whilst it is vital that ambulance clinicians maximise opportunities to deliver successful resuscitation attempts, it is equally important that where there are no reasonable prospects of delivering a successful outcome, patients are afforded the same opportunity for a dignified death. This procedure is therefore written to offer support to attending clinicians when faced with challenging circumstances where immediate decisions are required to be made as to whether resuscitation attempts are continued.

1.8. It is recognised that the decision to undertake resuscitation is a complex one. There are numerous competing factors that require to be balanced against each other before a decision can be made. It is therefore accepted that the attending clinician may only be in possession of limited information, be facing pressure from relatives and bystanders and feeling concern that criticism may be levelled at their decision. The primary concern in these circumstances should always be *'what is in the best interest of the patient?'* This does not always mean undertaking resuscitation but requires the clinician to take into account the patients circumstances and balance this against the invasive nature of resuscitation practice.

1.9. If it is felt that the presenting condition of the patient leaves little prospect of success, will give false hope to relatives and bystanders and does not afford the patient the prospect of a dignified death then resuscitation attempts should be considered as futile and no further attempts should be pursued.

1.10. Whilst no specific definition of futility exists, a joint statement by the British Medical Association (BMA) Resuscitation Council UK (RCUK) and Royal College of Nursing (RCN) in 2016, entitled 'Decisions relation to cardiopulmonary resuscitation,' states the following:

i.e. 'if the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period. If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted.'

1.11. This joint statement is also supplemented by the National Ambulance Services Medical Directors (NASMeD) Adult Cardiac Arrest best practice statement (2017) which documents:

a. *'Every effort should be made to identify patients with DNACPR orders, ReSPECT forms, treatment escalation plans or advanced directives.*
b. *Starting resuscitation inappropriately should be avoided if possible, and work should be undertaken locally to minimise this risk.*
c. *If ambulance clinicians are as certain as they can be that a person is dying as an inevitable result of underlying disease, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted or it should be abandoned if already started by the general public or CFRs.*
d. *Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.*
e. *Where there is uncertainty, it is acceptable to commence BLS whilst further information is gathered to enable the decision to be made on whether to then stop resuscitation*

1.12. However, there will be circumstances that even despite the perceived futility of the resuscitation attempts, the attending clinician feels it appropriate to commence. This is equally understandable and endorsed by this procedure.

1.13. This procedure uses recommended national guidelines, in conjunction with the contributions from the regions' Coroners, Police Services and Clinicians, and due consideration towards the End of Life Care Policy.

1.14. The procedure is comprised of 2 stages:

Stage 1 – Clinical diagnosis of Death
Stage 2 – Reporting the Fact of Death (see the relevant section for each County)

2. Definitions

Advanced Life Support	Advanced Life Support (ALS) Resuscitation practice incorporating Airway management with the use of a SAD or ETT, artificial ventilations, external chest compressions, IV or IO drug therapy and the use of a manual defibrillator.
Ambulance Technician/ AAP	A qualified healthcare professional, traditionally having undertaken an accredited programme with the Institute of Health Care Development (IHCD) or an Associate Ambulance Practitioner (AAP) qualification and, has completed a designated period of consolidated practice.
Apnoea	cessation of breathing
Asystole	Cardiac standstill or arrest; the absence of a heartbeat.
Basic Life Support	Basic Life Support (BLS) Resuscitation practice incorporating airway management, artificial ventilations, external chest compressions and the use of an AED.
Cannula	A thin tube inserted into a vein or cavity.
Coroner	A public officer whose role is to investigate the cause of a person's death.
DNACPR	A document that provides evidence that a patient should not receive CPR in the event of cardiac arrest (unless from an unrelated reversible cause for example choking).
DOLS	The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
ECG	An electrocardiogram. A means by which a healthcare professional can monitor the electrical impulses of a patient's heart.
EOC	Emergency Operations Centre
EPaCCS	Electronic Palliative Care Coordination System.

ETT	Endo Tracheal Tube. A device used to secure an airway through the use of a laryngoscope.
GP	In the medical profession, a general practitioner (GP) is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.
Hemicorporectomy	A below the waist amputation, transecting the lumbar spine.
Hypostasis	The accumulation of fluid or blood in the lower parts of the body or organs under the influence of gravity, as occurs in cases of poor circulation or after death.
Intravenous	IV. Gaining access to the vascular system through a vein.
Intraosseous	IO. Gaining access to the vascular system through the medullary space of a bone.
MOD	Ministry of Defence. The government department responsible for the Military.
Nurse	A Health Care Professional, operating across a broad range of practice within many healthcare settings. Registered with the Nursing and Midwifery Council (NMC).
OOH	Out of Hours. A period of time outside the normal operating hours of an organisation.
Paramedic	An Allied Health Professional, specialising in out of hospital & pre-hospital care. Registered with the Health & Care Professions Council (HCPC).
QMC	Queens Medical Centre.
Rigor mortis	Stiffening of the joints or muscles of a body a few hours after death. Usually lasting for one to four days.
SAD	A Supraglottic Airway Device. A Laryngeal Mask Airway or IGel.
Trainee Ambulance Technician	A healthcare professional, traditionally having undertaken an accredited programme with the Institute of Health Care Development (IHCD) or an

	Associate Ambulance Practitioner (AAP) qualification, but who has not completed a designated period of consolidated practice.

3. Stage 1 – Clinical Diagnosis of Death

3.1. The specific types of patients falling into the procedure can be divided into two main groups:

3.2. Group 1 – Conditions Unequivocally Associated with Death (Paramedics, AAP/Technicians Emergency Care Assistants) – No ECG required.

- Massive Cranial and cerebral destruction
- Hemicorporectomy or similar massive injury
- Decomposition/ putrefaction
- Incineration
- Hypostasis
- Rigor Mortis
- Foetal Maceration

3.3. In these groups, death can be recognised and recorded by the clinical confirmation of cardiac arrest and no ECG illustrating asystole is required.

3.4. Group 2 – Conditions Requiring ECG Evidence of Asystole (see procedure).

i) Patients recognised as life extinct who have received no **consistent and concerted** resuscitation attempts within 15 minutes following collapse and are now presenting in an asystolic rhythm (pacing spikes do not demonstrate a complex or a rhythm and in this context may be disregarded), with no pulse or respirations on arrival of the ambulance clinicians. **This may be carried out by Paramedics, Nurses and Ambulance Technicians/AAP.**

ii) Upon attendance at a patient in cardiac arrest, the attending clinician may determine that resuscitation attempts are futile and a successful outcome is not feasible. In this circumstance, the attending clinician may determine not to undertake further resuscitation attempts (see 1.7 & 1.12). This decision should be based upon the clinical presentation of the patient, their existing medical history and the background information that can be **ascertained at the time**. **This may be carried out by Paramedics, Nurses and Ambulance Technicians.**

iii) **Termination of resuscitation** attempts may take place if **continuous asystole is present** (pacing spikes do not demonstrate a complex or a rhythm and in this context may be disregarded), despite ADVANCED LIFE SUPPORT attempts, including IV/IO drug therapy, for more than 20 minutes in a normothermic patient. **This may be carried out by Paramedics and Nurses.**

iv) Patients who have been submerged for more than 90 minutes (this applies to both normothermic and hypothermic patients), with the exception of patients in the following circumstances:

- All those where there is a possibility of being able to breathe from a pocket of air whilst underwater.
- Anyone showing signs of life on initial rescue
- Those whose airway has only been intermittently submerged for the duration of their immersion, e.g. this wearing lifejackets but in whom the airway is being intermittently submerged, provided they still have a reasonably fresh appearance.

This may be carried out by Paramedic, Nurses and Ambulance Technicians.

4. Stage 2 – Reporting the fact of Death

4.1. General principles applicable to all areas.

Please note – None of the following County based procedures have a bearing on the decision as to whether to undertake resuscitation. These procedures ONLY relate to how the death is reported. In all cases the Diagnosis of Death form must be completed on the Eprf.

4.2 In all counties, the Police must be informed in the following circumstances:

- Where the circumstances are suspicious or cannot be explained
- If the deceased is under 18 years of age
- If the identity of the deceased cannot be confirmed?
- Where death did not occur in the home of the deceased or relative of the deceased (home includes residential home and gardens / yards etc) or in a public place
- If there is no known General Practitioner (GP) for the deceased
- Where there is no contactable next of kin
- Where there is insecurity at the premises or signs of forced entry;
- Deaths caused as a result of industrial or agricultural accidents and work-related deaths
- Murder/manslaughter
- Gunshot injuries
- Suffocation
- Hanging
- Drug overdose or suspicion of (intentional or not) including prescribed medicines
- Self-inflicted
- Poisoning – intentional or otherwise
- Electrocution
- Crush injuries
- Drug related deaths
- Deaths as a result of drowning including diving deaths
- Deaths in police or prison custody whilst serving a custodial sentence or if lawfully detained in any institution or under the Mental Capacity Act

- Deaths on the railway (responsibility of British Transport Police)
- Deaths at MOD Establishments
- Deaths as a result of fires
- Fatal road traffic collisions including pedal cycles and motability scooters
- In water
- Aircraft death
- Animal death
- Chemical related
- Decomposure
- If the body is taken out of the country

Any death not falling into the above categories will <u>not be authorised for a Coroner's removal.</u>

4.2. If the death occurs as the result of a road traffic collision and the road is closed with the scene secured by police, and provided that there is no public access that allows views of the deceased, ambulance crews will only remove the body in exceptional circumstances. This is at the request of the police and is related to accident investigation. Following the pronouncement of the fact of death, the police will assume responsibility for the body and arrange removal by their duty undertakers. The police will be responsible for notifying the relevant coroner.

4.3. The Diagnosis of Death Form must be completed by the crew member pronouncing the fact of death on the Eprf. The form must be fully and clearly completed.

4.4. If a Coroners Officer or Police Officer is at the scene, they should be advised how to request a Diagnosis of Death form.

4.5. A Diagnosis of Death Form should be completed on ALL occasions on the Eprf (Getac system). Including when a patient is transported to the Emergency Department and the attending hospital clinician determines that resuscitation attempts should be ceased, **whilst the patient still remains in the ambulance**. In turn allowing transportation of the deceased to the mortuary.

4.6. In the event the hospital clinician determines the patient is deceased, this should be documented on the form, stating the name of the clinician. The hospital clinician's signature is not required. The attending ambulance clinician is also not required to state they have pronounced death, merely that that death has been pronounced. This is to ensure that the Coroner receives timely notification of the patients' death.

4.7. Ambulance crews must not delay unnecessarily at the scene and it should be stressed that removal of deceased patients from domestic premises should only be undertaken in exceptional circumstances.

Reporting the Fact of Death Procedure for Lincolnshire.

To be undertaken following determination of the fact of death.

4.8. When a diagnosis of death has been made, in accordance with the procedure and/or an end of life care decision, the clinician needs to follow the procedure relevant to the location when death was verified. The Police will always be required to attend if there are suspicious or unexplained circumstances.

4.9. With the exception of North and North East Lincolnshire (where Humberside Police should be informed of **all** deaths in the community), Deaths that were **expected** are not required to be notified to Lincolnshire Police or Lincolnshire Coroner but the Diagnosis of Death Form must still be completed. If the family have a chosen undertaker the crew may assist in making arrangements for their attendance.

4.10. If there are suspicious or unexplained circumstances, death may be pronounced and the scene preserved until the Police arrive and assume responsibility. A Diagnosis of Death form should be completed via the Eprf and forwarded to the Coroner. Police will make arrangements for the Coroners designated undertaker to remove the deceased. If police officers on scene require a copy of the Diagnosis of Death form, they should be signposted how to request this via Information Governance.

4.11. **Unexplained Deaths** Police will be informed by EOC but may choose not to attend. If the police do not wish to attend:

4.11.1. The attending Paramedic, Nurse or Ambulance Technician will diagnose death within the set procedure and complete full documentation including the Diagnosis of Death Form on the Eprf.

4.11.2. The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend the scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).

4.11.3. If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the diagnosis of death form should be completed. There is no requirement for a Coroner's removal and the family should nominate their own funeral director to attend to remove the deceased. If the relatives/carers require help to contact a funeral director, the crew may provide such assistance, either directly themselves or by contacting EMAS EOC.

4.11.4. The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following

discussion and agreement with the relative of the deceased they may contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.

4.11.5. Invasive equipment must be left in situ following diagnosis of death. When attending non-suspicious deaths in the Lincolnshire area it is not necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with the existing clinical waste and management of sharps procedures.

4.11.6. Please see attached flowchart for reference which provides the Standard Operating Procedure.

Reporting of Fact of Death Procedure for Leicestershire.

To be undertaken following determination of the fact of death.

4.12. When a diagnosis of death has been made, in accordance with the procedure and/or an end of life care decision, the clinician needs to follow the procedure relevant to the location when death was verified. The police will always be required to attend if there are suspicious or unexplained circumstances. Police must be informed of all unexpected deaths by EOC but may decline to attend.

4.13. Deaths that were **expected** do not require to be notified to police but the Diagnosis of Death Form must still be completed and faxed to EOC for onward transmission to the relevant Coroner. If the family have a chosen undertaker the crew may assist in making arrangements for their attendance.

4.14. If there are **suspicious or unexplained c**ircumstances, death may be pronounced and the scene preserved until the Police arrive and assume responsibility. A Diagnosis of Death form should be completed and faxed to EOC or handed to the attending Police Officer.

4.15. **Sudden or unexpected deaths.** Police will be informed by EOC but may chose not to attend. If the police do not wish to attend:

4.15.1. The attending Paramedic, Nurse or Ambulance Technician will diagnose death within the set procedure and complete full documentation including the Diagnosis of Death Form.

4.15.2. The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend the scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).

4.15.3. If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the diagnosis of death form should be completed and faxed to EOC.

Please note, Leicestershire Police has a list of on-call funeral directors which will be made available to EMAS EOC. If the relatives/carers require help to contact a funeral director, the crew may provide such assistance, either directly themselves or by contacting EMAS EOC.

4.15.4. The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following discussion and agreement with the relative of the deceased they may contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.

4.15.5. When attending non-suspicious deaths in the Leicestershire area it is not necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures.

Reporting of Fact of Death Procedure for Nottinghamshire.

To be undertaken following determination of the fact of death.

4.16. In Nottinghamshire the Coroner has determined that deaths will fall into two categories:

i. Expected Death/Death is Not Unexpected
ii. Unexpected Death

4.17. Expected Death or Death Not Unexpected. This has the following definition:

a) There is documentary evidence that the patient was nearing the end of life and in receipt of end of life care in the form of end of life (EOL)/advanced care plans held in the patient's medical records at their GP Practice (often recorded as Gold Standards Framework 'yellow/amber' status).
b) Or Special Patient Notes held by the GP OOH provider
c) Or on the EPaCCS register.

Note: A DNACPR form alone is insufficient to state this was an expected death and should be confirmed with one of the examples above.

4.18. Unexpected Death. In the absence of any of the above documentary evidence the death should be classed as unexpected.

4.19. If there is no documentary evidence on scene the attending ambulance clinicians should contact the patients GP practice (during normal surgery opening hours) or the GP out-of-hours service. If the deceased's own GP practice or the out-of-hours service hold documentary evidence that the death was expected/not unexpected, there is no need to inform the police. The Family funeral director can be called to remove the body to their premises.

4.20. If there is no documentary evidence on scene the Police must be informed and requested to attend. The police will then decide whether or not a Funeral Director can be called to remove the body or whether the body needs to be removed by the Coroner's approved undertaker for transportation to the QMC mortuary.

4.21. If the Police do determine their attendance is necessary, then a minimum of one member of the attending ambulance clinicians should remain on scene and await their arrival.

4.22. In non-suspicious deaths it is no longer necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures and policies.

Reporting of Fact of Death Procedure for Northamptonshire.

To be undertaken following determination of the fact of death.

4.23. Northamptonshire Police will attend in all cases where a diagnosis of death has been made by EMAS staff if the death was unexpected or this cannot be established at the time. If the death was expected, crews should contact the patients GP in the first instance to see if the GP wishes to attend and is willing to issue a death certificate. If the GP cannot be contacted or is unable to issue a death certificate then the normal procedure for contacting the police should be followed.

4.24. If there are no suspicious circumstances, and a family member, carer or friend present at the scene is appropriately supported, EMAS staff will not normally wait for the police or GP to arrive.

4.25. Whilst at the scene, the ambulance clinician will complete the Diagnosis of Death form and patient record and leave these at the scene with a copy of the ECG in an envelope marked for the attention of the police and report the death to the Northamptonshire Police Communications Centre on 01604 432437. This number is for ambulance use only and should not be given to the general public. An incident number will be allocated to the call.

Relatives should be advised to call 08453 700700 and quote the incident number if police have not arrived within 60 minutes of the crew leaving.

4.26. The family should be advised that on arrival the police will make all necessary arrangements for removal of the deceased by the coroners' appointed undertakers. In no circumstances where the police attend will either the ambulance crew or Ambulance EOC make arrangements for removal of the deceased. The police will also be responsible for notifying the relevant coroner.

4.27. Following the pronouncement of the fact of death at an RTC, the police will assume responsibility for the body and arrange removal by the coroners' appointed undertakers. The police will be responsible for notifying the relevant coroner. A Diagnosis of Death form must be completed in the usual manner.

4.28. During office hours, crews may contact the coroners' offices from the scene for advice and guidance if required.

Kettering/Corby/Wellingborough and surrounding areas	01536 534827/534817
Northampton/Daventry/Towcester and surrounding areas	01604 703618/703619

Reporting of Fact of Death Procedure for Derbyshire.

To be undertaken following determination of the fact of death.

4.29. When a diagnosis of death has been made, in accordance with the procedure and/or an end of life care decision, clinicians need to follow the procedure relevant to the location when death was verified.

4.30. The police will only be required to attend if there are suspicious or unexplained circumstances. Police must be informed of all unexpected deaths by initially via 101. The senior officer in the police control room will contact the crew on scene to determine if there is a need to attend but in most cases they will decline to attend. For deaths that were expected the police do not need to be notified but the Diagnosis of Death Form must still be completed. If there are delays in contacting police control room via 101 this should be escalated via EOC who will contact the police

4.31. If there are suspicious or unexplained circumstances, death may be pronounced and the scene preserved until the police arrive and assume responsibility.

4.32. The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend they scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).

4.33. If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the ambulance clinician should advise the relatives/carers to contact their preferred funeral director to arrange the removal of the deceased. If the relatives/carers require help to contact a funeral director, the crew may provide such assistance, either directly themselves or by contacting Ambulance EOC.

4.34. The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following discussion with the

relative of the deceased they may make the judgement to contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.

4.35. It is no longer necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures and policies.

4.36. **EOC Fax Numbers**

Diagnosis of Death Procedure Fax Numbers:

Horizon Place EOC	*0115 8845493*
Lincolnshire Bracebridge Heath EOC	*01522 589924*

For **Northamptonshire** the documentation will be left on scene in a sealed envelope marked for the attention of the police or handed to them on their arrival.

5. Emergency Operations Centre Responsibilities

5.1. In Lincolnshire, upon notification from the attending ambulance clinicians of a sudden death, or termination of resuscitation attempts, EOC will inform the Police of a death in the community and confirm that the Police are making arrangements for the undertaker's attendance. This information should be logged within the CAD and also passed to the attending ambulance clinicians.

Coroner's email addresses by county

County	Coroners Email/Fax
Nottinghamshire	coroners.office@nottinghamcity.gov.uk
Derbyshire North (email all addresses)	coroner@derbyshire.gov.uk
Derbyshire South (email both addresses)	coroner@derbyshire.gov.uk
Leicestershire North & Rutland	northleics.coroner@nhs.net
Leicester City & Leicestershire South	leicester.coroner@nhs.net
Lincolnshire North & North East	Northleics.coroner@nhs.net
Lincolnshire Coroners	coronersofficers@lincolnshire.gcsx.gov.uk
Northamptonshire	CoronersNorthants@northants.pnn.police.uk

6. Consultation

6.1. Consultation in respect of this procedure has taken place with the following:

i. Each County's respective Coroners
ii. Operational Clinicians
iii. Each Counties respective Quality Lead
iv. EOC Service Delivery Managers
v. Clinical Governance Group
vi. Trust Coroner Manager

7. Monitoring Compliance and Effectiveness of the Procedure

7.1. Leadership of compliance with the procedure will be undertaken by the nominated Consultant Paramedic with assistance being undertaken by local management teams.

7.2. Any reporting of compliance will be undertaken through the Coroner Office and/or Clinical Governance Group.

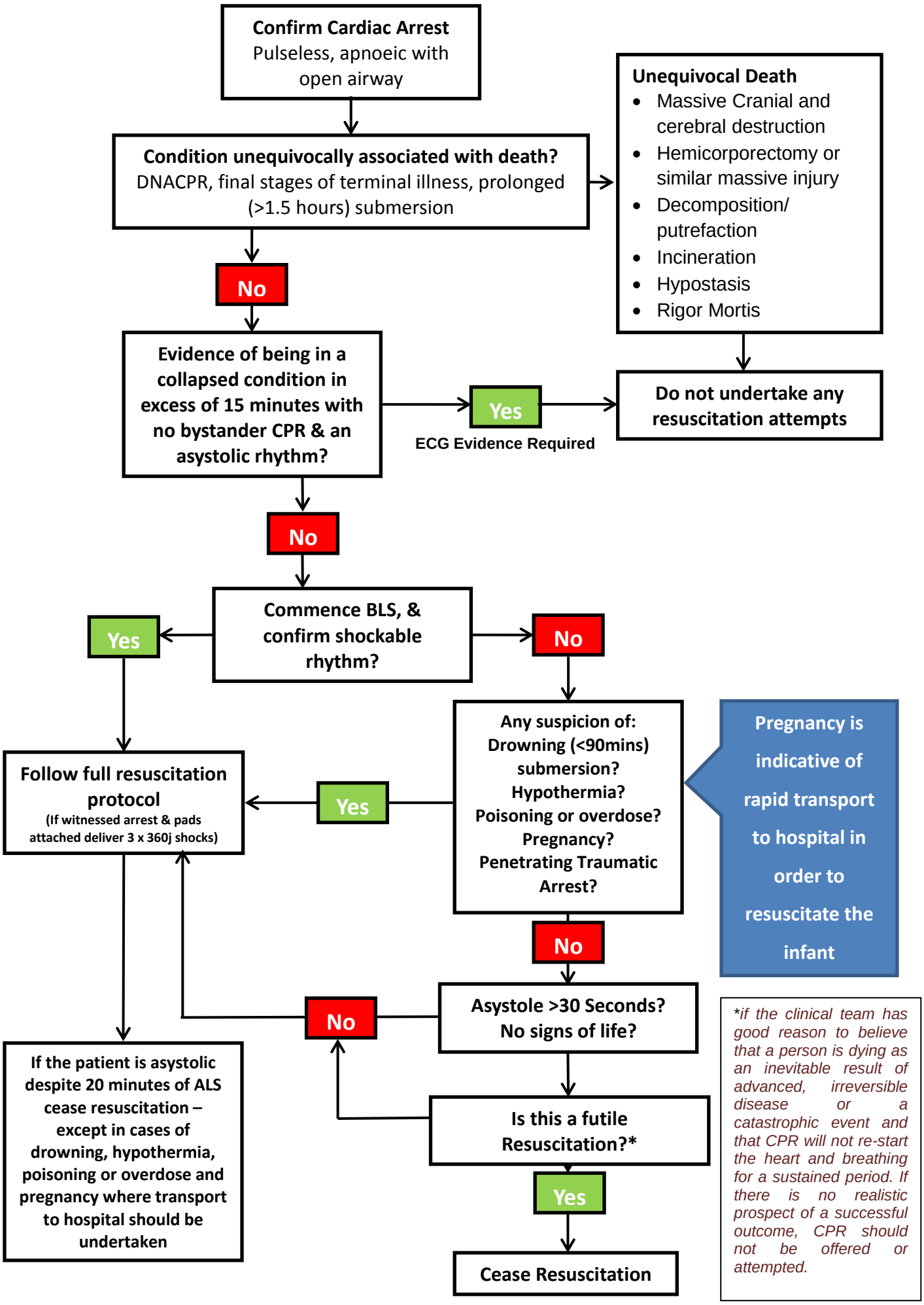
Appendix 1

Plan for Dissemination of Procedural Document

Title of document:	**Diagnosis of Death Procedure**		
Version Number:	**7.1**	**Dissemination lead: Print name, title and contact details**	**Roger Watson**
Previous document already being used?	**Yes**		
Who does the document need to be disseminated to?	All frontline clinicians, clinical leaders, EOC Staff and Operational Managers.		
Proposed methods of dissemination: **Including who will disseminate and when** Some examples of methods of disseminating information on procedural documents include: *Information cascade by managers* *Communication via Management/ Departmental/Team meetings* *Notice board administration* *Articles in bulletins* *Briefing roadshows* *Posting on the Intranet*	Disseminated through existing communications channels , ENEWS Local management teams		

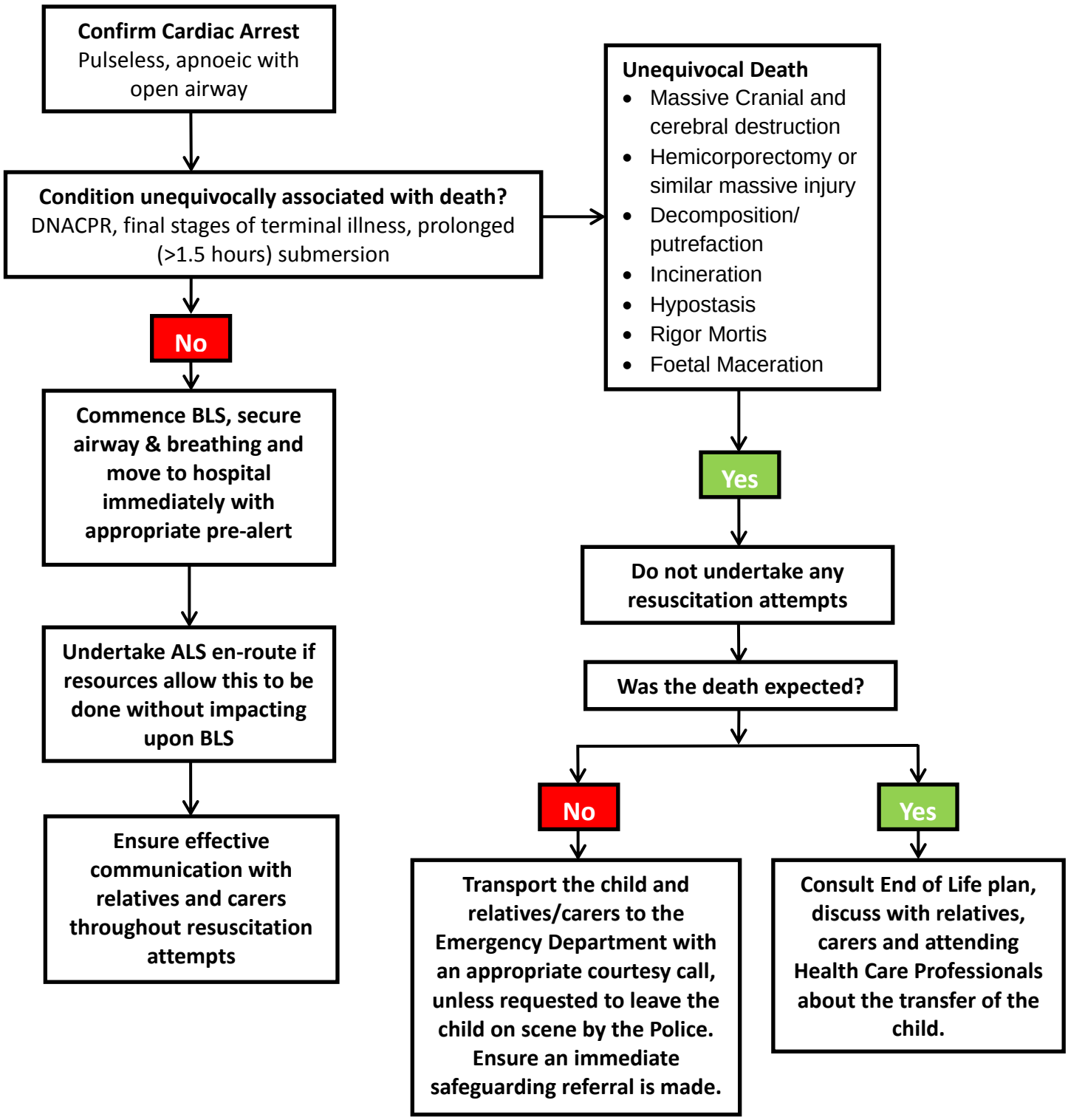
Note: Following approval of procedural documents it is imperative that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.

Adult Diagnosis of Death Flowchart (Medical & Trauma)



Appendix 3

Paediatric Diagnosis of Death Flowchart



In all circumstances the following must be undertake:

- Resuscitation of the child should always take place unless it is clearly inappropriate.
- The Diagnosis of Death Form should be completed in all circumstances when a child dies.
- For all child deaths EMAS staff should complete a safeguarding referral to ensure that a rapid response is initiated.

Appendix 4

East Midlands Ambulance Service NHS Trust

DIAGNOSIS OF DEATH

Sectioned under Mental health Act? Y / N	**Deprivation of Liberty Safeguards Order Y / N**	
	Court of protection order Y/N	
DATE	JOB No	CALL SIGN
TIME CALL RECEIVED	TIME ON SCENE	TIME LEFT SCENE
LOCATION OF INCIDENT (be as specific as possible)		
DECEASED'S FULL NAME (If Unidentified any possible identity info)		**MALE / FEMALE**
DATE OF BIRTH		***and*** AGE
DECEASED'S HOME ADDRESS		
POSTCODE	PHONE NUMBER	
I (full name)	hereby identify the deceased as	
SIGNATURE	RELATIONSHIP	CONTACT PHONE No
ADDRESS		
	POSTCODE	
DECEASED'S GP (name, if known)	CONTACT PHONE No	
SURGERY ADDRESS		
POSTCODE		
PMH and MEDs		

Diagnosis of death carried out in accordance with EMAS procedure or					**Y / N**
By other professional (*i.e., GP*)		(identify professional diagnosing death)			
Were there any unnatural circumstances requiring you to alert the Police					**Y / N**
POLICE INFORMED	**Y / N**	TIME : hrs	INCIDENT No.	ATTENDING	**Y / N**
Police incident number and or the police officer's collar number and telephone number (mandatory if police on scene):					

Events Leading Up To The Death and Any Additional Information: (including Deceased's Position When Found, e.g., supine at bottom of stairs, History of Events, Recent Hospitalisation, Details of Unnatural Circumstances, etc.)

PRONOUNCED LIFE EXTINCT AT : hrs		SIGNATURE	PIN	CALL SIGN
PRONOUNCED BY (*name*)				
WITNESSED BY (*name*)				
DR INFORMED (*Drs name*)		TIME : hrs	ATTENDING	**Y / N**
DECEASED'S NEXT OF KIN (*name*)		CONTACT PHONE No		
ADDRESS		NEXT OF KIN INFORMED		**Y / N**
POSTCODE		INFORMED BY:		
NAME OF ATTENDING FUNERAL DIRECTOR				
ARRANGED BY: EMAS / FAMILY / POLICE		CONTACT PHONE No		
LOCATION				

INFORM CONTROL OF UNIDENTIFIED PATIENTS AS THE POLICE MUST BE INFORMED AND ATTEND

PLEASE COMPLETE COMPREHENSIVELY. THE INFORMATION ON THIS FORM IS MANDATORY FOR HM CORONER.

It is incumbent on all clinicians to follow the correct procedure specific to the County in which the death has occurred.

Lincolnshire

When a diagnosis of death has been made, in accordance with the procedure and/or an end of life care decision, the clinician needs to follow the procedure relevant to the location when death was verified. The Police will always be required to attend if there are suspicious or unexplained circumstances.

With the exception of North and North East Lincolnshire (where Humberside Police should be informed of **all** deaths in the community), Deaths that were **expected** are not required to be notified to Lincolnshire Police but the Diagnosis of Death Form must still be completed and faxed to EOC for onward transmission to the relevant Coroner. If the family have a chosen undertaker the crew may assist in making arrangements for their attendance.

If there are **suspicious or unexplained c**ircumstances, death may be pronounced and the scene preserved until the Police arrive and assume responsibility. A Diagnosis of Death form should be completed.. Diagnosis of death forms should not be handed to police officers on scene. Police will make arrangements for the Coroners designated undertaker to remove the deceased.

Sudden or unexpected deaths. Police will be informed by EOC but may chose not to attend. If the police do not wish to attend:

The attending Paramedic, Nurse or Ambulance Technician will diagnose death within the set procedure and complete full documentation including the Diagnosis of Death Form.
The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend the scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).
If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the diagnosis of death form should be completed and faxed to EOC.
Please note, Lincolnshire, Police hold details of the nominated funeral director and will make the arrangements for their attendance at the scene.

The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following discussion and agreement with the relative of the deceased they may contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.

Invasive equipment must be left in situ following diagnosis of death.

Northamptonshire

Northamptonshire Police will attend in all cases where a diagnosis of death has been made by EMAS staff if the death was unexpected or this cannot be established at the time. If the death was expected, crews should contact the patients GP in the first instance to see if the GP wishes to attend and is willing to issue a death certificate. If the GP cannot be contacted or is unable to issue a death certificate then the normal procedure for contacting the police should be followed.
If there are no suspicious circumstances, and a family member, carer or friend present at the scene is appropriately supported, EMAS staff will not normally wait for the police or GP to arrive.
Whilst at the scene, the ambulance clinician will complete the Diagnosis of Death form and PRF/ePRF and leave these at the scene with a copy of the ECG in an envelope marked for the attention of the police and report the death to the Northamptonshire Police Communications Centre on 01604 432437. This number is for ambulance use only and should not be given to the general public. An incident number will be allocated to the call. Relatives should be advised to call 08453 700700 and quote the incident number if police have not arrived within 60 minutes of the crew leaving.
The family should be advised that on arrival the police will make all necessary arrangements for removal of the deceased by the coroners' appointed undertakers. In no circumstances where the police attend will either the ambulance crew or Ambulance EOC make arrangements for removal of the deceased. The police will also be responsible for notifying the relevant coroner.
Following the pronouncement of the fact of death at an RTC, the police will assume responsibility for the body and arrange removal by the coroners' appointed undertakers. The police will be responsible for notifying the relevant coroner. A Diagnosis of Death form must be completed in the usual manner.
During office hours, crews may contact the coroners' offices from the scene for advice and guidance if required:

Kettering/Corby/Wellingborough and surrounding areas	01536 534827/534817
Northampton/Daventry/Towcester and surrounding areas	01604 703618/703619

Derbyshire

The police will only be required to attend if there are suspicious or unexplained circumstances. Police must be informed of all unexpected deaths by EOC or via 101. The senior officer in the police control room will contact the crew on scene to determine if there is a need to attend but in most cases they will decline to attend. For deaths that were expected the police do not need to be notified but the Diagnosis of Death Form must still be completed and faxed to EOC for onward transmission to the Coroner.

If there are suspicious or unexplained circumstances, death may be pronounced and the scene preserved until the police arrive and assume responsibility.
The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend the scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).
If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the ambulance clinician should advise the relatives/carers to contact their preferred funeral director to arrange the removal of the deceased. If the relatives/carers require help to contact a funeral director, the crew may provide such assistance, either directly themselves or by contacting Ambulance EOC.

The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following discussion and agreement with the relative of the deceased they may contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.
It is no longer necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures and policies.

Nottinghamshire

In Nottinghamshire the Coroner has determined that deaths will fall into two categories:
- Expected Death/Death is Not Unexpected
- Unexpected Death

Expected Death or Death Not Unexpected. This has the following definition:

There is documentary evidence that the patient was nearing the end of life and in receipt of end of life care in the form of end of life (EOL)/advanced care plans held in the patient's medical records at their GP Practice (often recorded as Gold Standards Framework 'yellow/amber' status).
- Or Special Patient Notes held by the GP OOH provider
- Or on the EPaCCS register.

Note: A DNACPR form alone is insufficient to state this was an expected death and should be confirmed with one of the examples above.
Unexpected Death. In the absence of any of the above documentary evidence the death should be classed as unexpected.

If there is no documentary evidence on scene the attending ambulance clinicians should contact the patients GP practice (during normal surgery opening hours) or the GP out-of-hours service. If the deceased's own GP practice or the out-of-hours service hold documentary evidence that the death was expected/not unexpected, there is no need to inform the police. The Family funeral director can be called to remove the body to their premises.

If there is no documentary evidence on scene the Police must be informed and requested to attend. The police will then decide whether or not a Funeral Director can be called to remove the body or whether the body needs to be removed by the Coroner's approved undertaker for transportation to the QMC mortuary.
If the Police do determine their attendance is necessary, then a minimum of one member of the attending ambulance clinicians should remain on scene and await their arrival.

In non-suspicious deaths it is no longer necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures and policies.

Leicestershire

When a diagnosis of death has been made, in accordance with the procedure and/or an end of life care decision, the clinician needs to follow the procedure relevant to the location when death was verified. The police will only be required to attend if there are suspicious or unexplained circumstances. Police must be informed of all unexpected deaths by EOC but may decline to attend.

Deaths that were **expected** do not require to be notified to police but the Diagnosis of Death Form must still be completed and faxed to EOC for onward transmission to the relevant Coroner. If the family have a chosen undertaker the crew may assist in making arrangements for their attendance.

If there are **suspicious or unexplained c**ircumstances, death may be pronounced and the scene preserved until the Police arrive and assume responsibility. A Diagnosis of Death form should be completed and faxed to EOC or handed to the attending Police Officer.

Sudden or unexpected deaths. Police will be informed by EOC but may chose not to attend. If the police do not wish to attend:

The attending Paramedic, Nurse or Ambulance Technician will diagnose death within the set procedure and complete full documentation including the Diagnosis of Death Form.
The attending ambulance clinician will contact the patients GP or Out of Hours provider with patient details and inform them of the death. The GP will then be asked if they wish to attend the scene, if so they will be requested to attend within 20 minutes. (EOC will only be asked to assist with this if there is a problem contacting the GP or Out of Hours provider from scene).
If the GP does not wish to attend the scene or are unable to attend within 20 minutes, the diagnosis of death form should be completed and faxed to EOC.
Please note, Leicestershire Police has a list of on-call funeral directors which will be made available to EMAS EOC. If the relatives/carers require help to contact a funeral director, the crew may provide such assistance, either directly themselves or by contacting EMAS EOC.
The attending ambulance personnel will not normally wait at the scene until the funeral director or GP arrives if they believe the relative/carers of the deceased to be well supported with relatives/friends, and following discussion and agreement with the relative of the deceased they may contact EOC and leave the scene. The crew must ensure that the appropriate arrangements for the removal of the deceased have been made prior to departing the scene.
When attending non-suspicious deaths in the Leicestershire area it is not necessary to leave invasive equipment such as endotracheal tubes and IV cannulae in place after death. Such items may be removed and disposed of in accordance with existing clinical waste and management of sharps procedures

General Information

The Diagnosis of Death Form must be completed by the crew member pronouncing the fact of death and (with the exception of Northamptonshire) faxed to the EOC appropriate to your area at the earliest opportunity and in every case before the end of the shift. The form must be fully and clearly completed, as EOC will scan and email the form to the relevant Coroner on receipt. It is essential that all sections are fully completed.

Diagnosis of Death Procedure Fax Numbers:

Horizon Place EOC	0115 8845493
Lincolnshire Bracebridge Heath EOC	01522 589924

EOC function
On receipt of the completed form EOC will forward it to the relevant coroner's office.

For Northamptonshire the documentation will be left on scene in a sealed envelope marked for the attention of the police or handed to them on their arrival.