RECOGNITION OF DEATH IN THE COMMUNITY

A Regional Framework for the West Midlands

1 INTRODUCTION

1.1 In April 1999 the General Practitioners' Committee (GPC) of the British Medical Association published guidance for general practitioners on confirmation of death (Appendix 1). This included advice that there was no requirement, either legally or under the NHS Terms of Service, for a general practitioner to confirm the fact of death. Neither is there any legal requirement for death to be confirmed by a medical practitioner.

1.2 ***Confirmation*** of the fact of death is distinct from ***certification*** of the cause, time and place of death. Certification is an obligation on the doctor who attended the deceased during his or her last illness. Certification can only be carried out by a medical practitioner or a coroner.

1.3 The GPC guidance was issued to inform general practitioners of their obligations and also good practice. Its rapid dissemination was necessary because of changes in the organisation of general practice, especially out of hours, which make it increasingly likely that a doctor called to confirm death may not be the patient's own doctor. Because of this the confirmation of death and its certification have become separated. Doctors working out of hours may see no necessity to attend a death and procedures for alternative action are needed.

1.4 At the same time, in many cases of death, especially when unexpected, a 999 call may be made resulting in the attendance of an emergency ambulance. Because of the belief that a doctor is required to confirm death, procedures have developed which result in emergency ambulances waiting for the arrival of medical practitioners. In many cases the police are also routinely called even though there is no suspicion of foul play.

1.5 The West Midlands Regional LMC, a body which co-ordinates Local Medical Committees (statutory bodies representing general practitioners within the NHS) in the West Midlands, advised their constituents to delay implementing local procedures until a region-wide framework could be developed. This would enable a consistent approach to be taken with resulting minimisation of confusion and problems.

1.6 Following a regional conference involving all ambulance and police services as well as representatives from health authorities, HM Coroners and the RLMC, a draft framework was drawn up and circulated for consultation to these services and also Local Medical Committees in the region. The responses received were used to shape this framework which has been agreed by the Regional LMC. The framework is intended to be used by local services to agree their procedures and its implementation will depend on local circumstances.

1.7 Section 2 explains the terminology used in the framework.
Sections 3 - 6 advise personnel attending a death on procedures to follow
Section 7 is a guidance note for general practitioners
Section 8 is guidance or GP out of hours organisations responding to calls about deaths
Section 9 contains recommendations on training
Section 10 is a concluding note

2 TERMINOLOGY

2.1 For the avoidance of ambiguity it is recommended that the term *recognition of death* should be used instead of *confirmation* to avoid confusion with certification.

2.2 **Caller:** a person present at the scene of death who is contacting a third party for advice on what to do when they think someone has died.

2.2 **Patient / Deceased:** the person who has died.

2.3 **Expected death:** a death where the patient was expected to die or who friends or family had been informed was terminally ill or likely to die.

2.4 **Unexpected death:** a death where there was no expectation that the patient was terminally ill or likely to die. This should include sudden death.

2.5 **Suspicious death:** a death where there is suspicion or signs of violence, accident, poisoning or suicide.

2.6 **Unexplained death**: a death where there is insufficient evidence available to assist in determining the likely cause of death. This should be dealt with in the same way as a suspicious death.

3 PROCEDURES FOR RECOGNITION OF DEATH

3.1 Ambulance personnel:
JCALC guidelines should be used (appendix 2)

3.2 Doctors, nurses (RGN or RMN), trained police officers and trained carers (eg in residential homes)

3.2.1 Exclusions:

children	)
pregnant / possibly pregnant	)
overdose	)call ambulance
hypothermia	)
electrocution	)

3.2.2 Procedure:

*Examine pupils with a bright light	-pupils fixed and dilated
*Look, listen, feel for breathing	-no signs of respiration
*Hold mirror near / over the mouth	-no condensation on mirror
*Feel for pulse / apex of heart	-no pulse / apex beat
*Listen with stethoscope over left anterior chest wall for five minutes in a quiet room	-no audible or visible signs of breathing or heart beat.

*Inspect the body for external signs of accident, violence, poisoning or suicide (eg injuries)

4 EXPECTED DEATHS

Action After Carrying Out Recognition Procedure

4.1 Advise next of kin or other relative that the patient has died and give information on what to do after a death (Appendix 3).

4.2 Contact general practitioner:
advise patient has died
ascertain arrangements for certification
ascertain whether GP intends to visit before removal of body
advise those present of the outcome of these discussions

4.3 If GP not attending before removal of body advise relatives they can contact undertaker for removal of body.

4.4 Ambulance crew or other services called in may withdraw

5 SUDDEN ,VIOLENT OR UNEXPECTED DEATHS - SIGNS OF SUSPICIOUS DEATH UNEXPLAINED DEATHS

Action After Carrying Out Recognition Procedure

5.1 Contact police and request attendance of police officer. Do not move the body or disturb the scene of death. It is the responsibility of the police to inform the coroner and to arrange the attendance of the police surgeon / forensic medical examiner if appropriate.

5.2 Advising next of kin or relative in these circumstances is the role of the police and dependent on the circumstances. It is practical to give brief necessary information to those present to explain that the police have been called and they will deal with further information.

5.3 Contact general practitioner:
advise patient has died and that police have been contacted
ascertain whether general practitioner intends to visit.
advise those present of the outcome of these discussions

5.4 The police will normally contact the coroner.

5.5 Remain at the scene until police arrive.

6 UNEXPECTED DEATH - NO SIGNS OF SUSPICIOUS / UNEXPLAINED DEATH

Action After Carrying Out Recognition Procedure

6.1 Advise next of kin or other relative that the patient has died and give information on what to do after a death (Appendix 3).

6.2 Contact general practitioner:
- advise patient has died
- ascertain arrangements for certification
- ascertain whether GP intends to visit before removal of body
- advise those present of the outcome of these discussions

6.3 If GP not attending before removal of body advise relatives they can contact undertaker for removal of body.

6.4 Ambulance crew or other services called in may withdraw

7 GUIDANCE FOR GENERAL PRACTITIONERS

7.1 The general practitioner will at all times consider the needs of living persons and these include the relatives of the deceased as well as other patients, even if they are not registered with the doctor. If the general practitioner will be the certifying doctor it is good practice to arrange to see the deceased as soon as practicable. This need not delay the removal of the body to the undertaker's premises, but may be conveniently done while the undertaker is awaited, and appropriate bereavement counselling be given to the relatives and family. Where the certifying doctor (usually the deceased's own general practitioner) is not available, another doctor should assess whether a visit is needed to meet the needs of living patients (eg bereaved relatives).

8 GUIDANCE FOR OUT OF HOURS ORGANISATIONS / DEPUTY DOCTORS

8.1 If a deputy general practitioner or out of hours organisation is contacted about a death an assessment should be carried out to decide whether a visit is appropriate. The deputy doctor will not be the certifying doctor and is unlikely to have any connection with the relatives or any access to the medical records. A visit will probably be appropriate when there is no person competent to undertake the procedure for recognition of death, where there is uncertainty about the fact of death or to meet the needs of living patients (eg bereaved relatives).

8.2 TELEPHONE ASSESSMENT BY GP OUT OF HOURS ORGANISATIONS
Full details must be taken of the identity of the deceased as well as the name and address of the caller and their relationship to the deceased.

8.2.1 Where is call coming from?
- Emergency ambulance crew
- Community based nurse
- Staff at nursing home
- Staff at residential home
- Police
- Member of the public

8.2.2 Call from Emergency Ambulance Crew

a) Has the caller carried out recognition of death procedure?
If No -advise to carry out
if Yes -proceed to b

b) Does patient fit criteria?
If No -advise proceed to A&E
If Yes -proceed to c

c) Are there any signs of violence, poisoning, accident or suicide?
If Yes -advise contact police and request attendance (see 5)
If No -proceed to d

d) Is there any reason for medical intervention?
If Yes -assess need and act accordingly
If No -advise informant / relative they may contact undertaker;

e) Check any special instructions from patient's own GP and act accordingly
Send full information to patient's own GP as soon as possible
Follow up call after 30 mins to check relatives etc confident.
Advise ambulance crew may withdraw

8.2.3 Call from Nursing Home or Nurse in the Community
Caller should be RGN or RMN or trained in recognition of death procedure

a) Has caller carried out recognition of death procedure?
If No -advise to carry out
If Yes -proceed to b

b) Does patient fit criteria?
If No -assess need for medical intervention
If Yes -proceed to c

c) Was the death expected?
If yes -advise contact undertaker to arrange removal of body
If no -proceed to d

d) Are there any signs of violence, poisoning, accident or suicide?
If Yes -advise contact police and request attendance (see 5)
If No -proceed to e

e) Is there any reason for medical intervention?
If Yes -assess need
If No -advise contact undertaker

f) Check any special instructions from patient's own GP and act accordingly
Send full information to patient's own GP as soon as possible
Follow up call after 30 mins to check relatives, staff confident.

8.2.4 Call from Residential Home

Caller should be trained in recognition of death procedure. If no competent person is available, call should be dealt with as from a member of the public (8.2.5).

a) Has the caller or a trained person carried out recognition of death procedure?
If No -advise to carry out
If Yes -proceed to b

b) Does patient fit criteria?
If No -assess need for medical intervention
If Yes -proceed to c

c) Was the death expected?
If yes -advise contact undertaker to arrange removal of body
if no -proceed to d

d) Are there any signs of violence, poisoning, accident or suicide?
If Yes -advise contact police and request attendance (see 5)
If No -proceed to e

e) Is there any reason for medical intervention?
If Yes -assess need and act accordingly
If No -advise contact undertaker

f) Check any special instructions from patient's own GP and act accordingly
Send full information to patient's own GP as soon as possible
Follow up call after 30 mins to check staff confident.

8.2.5 Call from Member of the Public

a) Was death expected?
If Yes - arrange for competent person to attend to carry out recognition procedure: usually doctor’s visit needed.
If No - proceed to b

b) Is the patient showing any signs of life, eg breathing, movement, sounds
If Yes - advise dial 999, ask for ambulance
If No - proceed to c

c) Is there any suspicion of violence, poisoning, accident or suicide?
If Yes - advise dial 999, ask for ambulance
If No -arrange for competent person to attend to carry out recognition procedure: usually doctor’s visit needed

d) Check any special instructions from patient's own GP and act accordingly
Send full information to patient's own GP as soon as possible

8.2.6 Call from Police

Caller should be trained in recognition of death procedure. If no competent person is available, call should be dealt with as from a member of the public (8.2.5).

a) Has the caller or a trained person carried out recognition of death procedure?
If No -advise to carry out
If Yes -proceed to b

b) Does patient fit criteria?
If No -assess need for medical intervention
If Yes -proceed to c

c) Was the death expected?
If yes -advise contact undertaker to arrange removal of body
if no -proceed to d

d) Are there any signs of violence, poisoning, accident or suicide?
If Yes -advise act according to normal police procedure (see 5)
If No -proceed to e

e) Is there any reason for medical intervention?
If Yes -assess need and act accordingly
If No -advise contact undertaker

f) Check any special instructions from patient's own GP and act accordingly
Send full information to patient's own GP as soon as possible

9 TRAINING

9.1 Ambulance services
Ambulance crews should be familiar with the JCALC guidance and trained in its operation.

9.2 Residential Homes
Residential homes should ensure access to a member of staff trained in the recognition of death.

9.3 Nursing Homes
Nursing homes should ensure access to a nurse (RGN or RMN) or a member of staff trained in the recognition of death.

9.4 Community Nurses
Nursing staff working in domiciliary settings should be trained in the recognition of death

9.5 Social Services
Social services staff working in domiciliary settings should be trained in the recognition of death.

9.6 Police
Police officers should be trained in the recognition of death.

9.7 Training schemes

Consideration should be given to the development of standard training to ensure that all emergency, health and social care services personnel likely to encounter death should be competent in procedures for the recognition of death and the procedures for expected, unexpected, suspicious and unexplained death.

10 CONCLUSION

This framework is not prescriptive and cannot cover every eventuality. It is intended as a basis on which local arrangements can be agreed between local organisations such as the Local Medical Committee, GP Out of Hours Organisations, NHS Community and Ambulance Service Trusts, Coroners, Police, Nursing Homes, Health Authorities, Primary Care Organisations, Local Authorities (residential homes and social services) and local undertakers.

The framework is under continual review and comments are welcome.

September 2000

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APPENDIX 1

April 1999

GPC

General Practitioners
Committee

Confirmation and certification of death

Guidance for GPs in England and Wales

CONFIRMATION AND CERTIFICATION OF DEATH

1. Introduction

This guidance aims to clarify the distinction between confirming and certifying death in relation to GPs' obligations.
English law:
does not require a doctor to confirm death has occurred or that "life is extinct";
does not require a doctor to view the body of a deceased person;
does not require a doctor to report the fact that death has occurred;
does require the doctor who attended the deceased during the last illness to issue a certificate detailing the cause of death.

(i) Expected deaths of patients
If the death occurs in the patient's own home, it is wise to visit as soon as the urgent needs of living patients permit.
If the death occurs in a residential or nursing home and the GP who attended the patient during the last illness is available, it is sensible for him/her to attend when practicable and issue a death certificate.
If an "on-call" doctor is on duty, whether in or out of hours, it is unlikely that any useful purpose will be served by that doctor attending. In such cases we recommend that the GP advises the home to contact the undertaker if they wish the body to be removed and ensures that the GP with whom the patient was registered is notified as soon as practicable.

(ii) Unexpected ("sudden") deaths
If death occurs in the patient's home, or in a residential or nursing home, we recommend a visit by the GP with whom the patient was registered, to examine the body and confirm death, although this is not a statutory requirement. The GP should then report the death to the coroner (usually through the local police).
In any other circumstances, the request to attend is likely to have come from the police or ambulance service. It is usually wise, and especially in the case of an Aon-call@ doctor, to decline to attend and advise that the services of a retained police surgeon be obtained by the caller.

2. Legal requirements

The law requires a doctor to notify the cause of death of any patient whom he/she has attended during that patient's last illness to the Registrar of Births and Deaths. The doctor is required to notify the cause of death as a certificate, on a form prescribed, stating to the best of his/her knowledge and belief, the cause of death. It should be noted that the strict interpretation of the law is that the doctor shall notify the cause of death, not the fact. Thus, a doctor does not certify that death has occurred, only what in his/her opinion was the cause, assuming that death has taken place. Arising out of this interpretation there is no obligation on the doctor even to see, let alone examine the body before issuing the certificate. The Broderick report recommended that a doctor should be required to inspect the body of a deceased person before issuing the certificate but this recommendation has never been implemented. Thus, there is no requirement in English law for a general practitioner or any other registered medical practitioner to see or examine the body of a person who is said to be dead. General practitioners as a body would not, and as individuals should not, seek to use this quirk of English law to avoid attending upon an apparently deceased patient for whom the GP is responsible. However, the fact that there is no legal obligation upon a GP to attend a corpse should be remembered

and, if necessary, quoted when organisations such as the emergency services ask general practitioners, either in or out of hours, to attend a corpse as a matter of urgency. If a patient is declared to be dead by a relative, a member of staff in a nursing home, ambulance personnel or the police, GPs would be quite right to explain that the needs of the living must take priority over the requirements of the dead. On a parallel basis, case law exists to confirm that a NHS general practitioner does not have a contractual obligation to attend upon the body of a patient declared to be dead. Once again the fact that a contractual obligation does not exist should never be used by GPs to avoid the ethical and moral responsibility to make the experience of bereavement as gentle and easy as possible for relatives and friends.

3. Sudden or unexpected deaths

These fall into two main categories:

(i) deaths where there is prima facie evidence of violence or other unnatural causes, including deaths in road traffic accidents, falls from high places, suicides and those apparently involving criminal violence;
and

(ii) sudden or unexpected death where there is no prima facie evidence of violence or unnatural causes.

GPs are advised to be cautious in making or attempting to make this distinction unless they are forensically trained and experienced in clinical forensic medicine. It is too easy to wrongly classify a sudden or unexpected death.

As a citizen, a doctor has an obligation to inform the police if he/she becomes aware of a serious crime but English law, contrary to popular belief, does NOT place an obligation upon a doctor to report all sudden deaths to the coroner. In practice, the wise practitioner will report a sudden death to the coroner, normally through the agency of the local police.

The most likely circumstances in which GPs may be requested to attend upon the body of a victim of sudden death are:

(i) A call from a relative or a nursing or residential home, about a registered patient who has been found to be dead, unexpectedly, but apparently in circumstances which are not suspicious. The doctor should respond as quickly as the urgent needs of their living patients permit. On arrival the doctor should carry out an adequate examination to confirm death and then consider whether the coroner should be informed. In all but very exceptional circumstances, even where there appear to be no suspicious circumstances, the doctor would be wise to notify the coroner. The GP should be mindful of the considerable distress this may cause to relatives and friends and explain why the police will attend and the likely course of events subsequent to the attendance of the police.

(ii) A request from the police, or ambulance service that the GP attend upon a body found in a public place, a deserted building or as the result of a road or other form of accident or other situation. In these circumstances there is no obligation upon the GP to attend. Under paragraph 4(1)(h)(iii) of the terms of service, a NHS GP is required to provide *treatment* to persons not registered but requiring immediate treatment due to an accident or other emergency only if "he is available to provide such treatment". If the request is to attend upon a dead person or persons there is no question of a GP being requested to provide treatment, therefore there is no obligation to attend.

If the request is to attend to treat a person as a result of an accident it may be that the GP, whether the call is in working hours or out of working hours, is available and considers it would not endanger the other patients for whom he/she is responsible to attend the emergency. It would then be right and reasonable for the doctor to attend. However, if the doctor is on call and dealing with numerous calls as when on duty for a co-operative or dealing with patients attending a surgery session, then it is reasonable to give a reply which indicates that the doctor is not available to provide such treatment.
If the police request a GP to attend a sudden death, unless that doctor is trained and experienced in clinical forensic medicine and the police offer the appropriate fee for the service, then the GP would be well advised to refuse to attend and advise the police to obtain the services of a retained police surgeon. If the request comes from the ambulance service then the response should be to advise the ambulance service that a doctor is not available and suggest that they ask the police to enlist the services of a retained police surgeon.

4. Expected deaths at home or in nursing or residential homes

(i) Calls during normal working hours
A doctor who has been treating the patient during their current illness should indicate that he/she will attend as soon as the urgent needs of any living patients have been satisfied. The doctor should then attend to confirm death and issue the appropriate death certificate. If the doctor who has been treating the patient is not immediately available, a colleague should attend and then ensure that the doctor of the deceased patient is informed of the death as soon as possible.

(ii) Calls out of hours
The likelihood is that the doctor on call is not the doctor who has been attending the deceased person during their last illness, and cannot therefore initiate the death certification process. If the death is in a nursing or residential home it is unlikely that any useful purpose can be served by a duty doctor attending during the out of hours period unless there is a genuine doubt as to whether the person is dead.
The obligation upon the on-call doctor or the co-operative, in those circumstances, is to ensure that the deceased's registered GP is notified at the first possible opportunity in the next period of normal working hours. It is then the responsibility of the doctor with whom the deceased was registered to deal with the death certification procedure. If the home so requests, normally undertakers will remove bodies under these circumstances.
The circumstances are similar if the person has died at home but, on those occasions, it may well be that there is a distressed relative or friend who reasonably requires the attention of the doctor. If, however, the relative is content to make arrangements with an undertaker, without the doctor attending, then there is certainly no need for a duty doctor to attend.

5. Problem situations

It is inevitable that on occasion expected deaths will occur at times when the general practitioner who has been treating the patient during the last illness is not available at the time or during the next period of normal working hours. Whilst partners sometimes take what they deem to be the kindest action to deal with the situation and issue a death certificate, the proper course of action and very much the wisest is for the partner or colleague of the absent practitioner to notify the coroner personally in those circumstances. Coroners are understanding of the doctor's position and sympathetic to the relatives' situation and will, normally, issue appropriate instructions to allow the funeral arrangements to proceed without unnecessary bureaucratic delay.

West Midlands Regional LMC
September 2000
APPENDIX 2
JCALC GUIDELINES FOR AMBULANCE PERSONNEL
Insert copy of JCALC guidance (Only available as hard copy)