Care after Death Guidelines For the Adult Patient

This guidance does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

PURPOSE

Care after death is the term for the nursing care given to a deceased patient. It demonstrates continued respect for the patient as an individual (NMC 2018)[1], whilst recognising a wider range of care tasks that need to be performed, and acknowledges our multicultural society (Thompson-Hill and Mackleston, 2012)[2].
These guidelines support the use of the Integrated Care after death Pathway (WR4888), a document which records and prompts care in the different areas that the deceased is cared for - on the wards, transfer by porters to the mortuary, in the mortuary and supporting work in the bereavement office.
These guidelines will now also include the procedures to support care after death of the patient who has confirmed, or suspected COVID-19 infection.

Lead Clinician(s)

Avril Adams	Lead nurse for Palliative & EOLC
Tess Makinson Alice Ferguson Juliette Fleming	WAHT End of life Care Facilitators
Guideline approved by Trust Management Executive on:	27th April 2023
Review Date: This is the most current document and should be used until a revised version is in place	27th October 2026

Key amendments to this guideline

Date	Amendment	By:
March 2010	Guideline approved by	Matrons Forum
15/09/2010	Organ/Tissue donation	S Ellson
15/09/2010	Appendix 2 – Guidelines for handling cadavers with infections	H Gentry
06/03/2012	Extended for 3 months to allow time for review	J Garside
20/04/2012	Extended for a further 3 months to allow time for review	J Garside
10/10/2012	Extended for a further 3 months to allow time for review	J Garside
07/01/2013	Republished without changes	J Garside
08/02/2013	Republished without changes	A Carey
08/08/2013	Amendments made to introduction, contact details and newly introduced Bereavement card, KGH, death outside of ward area.	T Barley
11/08/15	Amendments made throughout document in line with introduction of new National guidance around care after death (2015)	T.Makinson
09/08/16	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
29/03/2017	Document extended for 6 months while amendments needed owing to introduction of ICADP	High Impact Action Group: End of life
01/09/2017	Document extended for 3 months as per TMC paper approved 22nd July 2015	TMC
November 2017	Document extended whilst under review	TLG
December 2017	Sentence added in at the request of the Coroner	
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
March 2019	Amendments made throughout document in line with introduction and implementation of Integrated Care after Death for Adults, WR4888 Trustwide	T. Makinson
August 2022	Document extended for 3 months to allow time for a thorough review	T. Makinson
December 2022	Review and amendments most especially to include COVID 19 documentation and policy.	Avril Adams Juliette Fleming Alice Ferguson
12th February 2026	Document extended for 6 months from review date (27/04/2026) as requested to allow time for review and update	Dr Mandeep Uppal

Care After Death Guidance

INTRODUCTION

Comprehensive care after death given to a deceased patient demonstrates continued respect for the patient as an individual and in contemporary society is focused on fulfilling religious and cultural beliefs as well as health and safety and legal requirements (Lister and Dougherty 2008[3]).

Practices relating to care after death will vary depending on the patient's religious and cultural background. The UK today is a multicultural and multi-faith society and nursing staff need to be aware of the different religious and cultural rituals that may accompany the death of a patient. If needed, further information and support can be sought through the local Chaplaincy team. Bereavement office and Mortuary staff support processes for early release of the body for religious reasons.[4]

Care following an expected death can be different to that given to a patient who has died suddenly, suspiciously, unexpectedly, or in a critical care setting and therefore senior nursing or medical staff should be consulted before starting care after death, (Nurse Consultants, 2015.)[4]

Factors which may need consideration include:

- Referral to coroner
- Suspicious deaths
- High risk infections
- Organ/Tissue donation
- Implanted radioactive materials - as these will require removal prior to discharge from the Hospital – please contact medical staff and inform mortuary.

Bereaved people value the support of bereavement services and the professionals that provide them and it has been shown that the experience around the time of death and afterwards can influence grieving and the longer term health of bereaved people (DOH 2011).[5]

COMPETENCIES REQUIRED

Care after death must be completed under the supervision of a registered nurse who has responsibility for this care including identification and completion of all documentation.

This guideline describes the local procedure for care after death and responsibilities of the nurse in charge of the adult patient (aged 18 years and over) from the time of death until the patient leaves the ward, in line with National guidelines[4].
All deceased adult patients should have the document Integrated Care after death Pathway WR4888 fully completed.

Following last breath of a Patient - Procedure for those where Integrated care after death pathway- WR448 is used.

Action	Rationale
Care on the ward, WRH and ALEX sites Inform the medical staff and site nursing Bleep holder of the patient's death.	A registered medical practitioner who has attended the deceased person during the last illness is required to give a medical certificate of the cause of death. The certificate requires the doctor to state the last date on which he/she saw the deceased alive and whether or not he/she has seen the body after death
Ward nurse to document the death and record time of last breath sounds. Verification of death must be recorded in the patient's medical and nursing notes. The expected standard is verification within an hour of the patient's last breath sounds.	It is an important part of the patient record, often sought by NOK and can aid audit of time to verification which is "legal" time of death. Verification of death is not the same as certification.
All doctors can verify death. Those registered nurses who have successfully completed training and competencies in the Trust may verify an expected adult death.	Trust policy Verification of expected death in adults for registered nurses WAHT-CG-681
Contact hospital bereavement office to inform them of the patient's death and they will collect the notes, – out of hours leave a discrete message on their answerphone.	For confidentiality, leave anonymised message that a death has occurred on Ward….
If the patient has an implanted device such as a pacemaker/ICD – please record this fact on both Notice of death cards and pathway and whether the ICD has been deactivated.[6] All deceased patients must have an Infection and Communicable disease risk of transmission assessment tool completed. These are part of the Integrated care after death pathway for Adults (WR4888)	Implanted devices may present a hazard at cremation The RN is responsible for completion of all documentation around care given after death. It is crucial to communicate any risk of transmission of disease and infection to those who handle the body after the ward staff especially as the notes will not go to the mortuary

Organ &Tissue donation If the patient has expressed a wish to be considered as an Organ/Tissue Donor in their lifetime by either carrying a donor card or registering on the Organ Donor Register or if relatives bring up the subject of donation, Ward staff please contact the on call National Tissue Co-ordinator on 0800 432 0559 for Tissue donation. The Specialist Nurse in Organ Donation can be contacted via Switchboard or contact ITU fro advice.	Organ donation can only happen if patient is in an ITU setting. Tissue donation may be possible if patients have died on ward areas.
Care of the family/NOK	
Inform Family/NOK of the death in a sensitive, honest and supportive way. If family cannot be contacted inform the hospital bleep holder.	To ensure relevant individuals are aware of the patient's death Be clear, do not use euphemisms. Be honest do not say they are "poorly" "deteriorating" if they have actually died. Document the conversation.
If relatives are present at the time of death, or attend the hospital shortly afterwards, staff should ensure that they are given a Bereavement Information pack and shown Bereavement contact details.	
If relatives are present they may take the patient's belongings providing they sign the property book.	Staff to put property in the SUPPORT bereavement property bags and jewellery pouches.
If relatives are not present, but are contacted by staff over the phone they need to be informed of the contact number for Bereavement office who will be available from 09.30am on the next working day.	
Relatives should be asked to contact the relevant Trust bereavement office for information on collection of property and processing of death certification.	Since 2020 Death certificates are send electronically to the Register Office. Relatives no longer need to visit the Hospital bereavement office, in person.
Jewellery and valuables	
Remove all jewellery except wedding band in the presence of another member of staff, unless requested by the family to do otherwise and document accordingly. If rings are left on tape lightly in place.	For security of jewellery
Any jewellery remaining on the body should be documented on the Notice of death cards, (WR420) accompanying the patient to the mortuary	To meet with legal requirements and relatives' wishes.

Record all jewellery, valuables and other property in the patient's notes and in the ward property book.. Keep valuables safe and document what they are and location for when they are collected. Ask relatives to sign for and print their name and contact details if they receive jewellery/valuables from ward staff.	Be specific when describing jewellery, noting colour of metal, colour and number of stones for accuracy. For reference if there are any issues
Nursing Care after death **Equipment needed** Bowl, soap, towels, disposable wipes, gloves, and apron Hair comb, equipment for nail care Equipment for oral care including aids for cleaning dentures Shroud or patient's own nightclothes Clean sheets Disposable body bag is to be used at all sites Trust wide, for all deceased patients. Dressing pack, tape and occlusive dressings if wounds present Syringe (to deflate balloon if urinary catheter present) Continence pad and disposable pants if exuding fluid Appropriate Yellow plastic bag for clinical waste White/red plastic bag for dirty linen Patient identification bands (3) Notice of death cards (2) WR420 Property book, jewellery pouch, and bereavement property bags Integrated Care Pathway for Patient Care After Death for Adults WR4888 ICADP **Consider the circumstances of the death,**	Patient's property can be returned in hessian bag and bereavement items – candle and forget-me-not-seeds and organza bag for jewellery or other tokens can be offered if felt to be appropriate. Supplies can be found on the ward. Request more from the Palliative and End of Life Care Team.

If the circumstances surrounding the death give rise to suspicion that means the death requires forensic investigation, leave all intravenous cannula and lines in situ and intravenous infusions clamped but intact (this includes syringe drivers with controlled drugs). Leave any catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case it destroys evidence. Continue using universal infection measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death.	This would be a death where the police are involved.
Death in hospital of a patient under the care of the prison service, (in custody). The death is always referred to the coroner. Guidance will be given by the prison Governor and the prison family liaison service will inform any next of kin.	Prison officers who are present will contact the prison governor who will advise re process.
Where the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, Leave intravenous cannula and lines in situ and cover with an occlusive dressing.	Care after death is given as when coroner involvement. Deaths in certain circumstances must be referred to the coroner for investigation and may require a post mortem – See Appendix 1 Refer to and Complete Coroners tick list in Integrated Care after death pathway (WR4888)
Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation.	The medication name, dose and route and The volume infused and to be infused (discarded) should be noted in the patient record. To ensure relevant and accurate recording of infused drugs.
Urinary catheters should be left in place and bunged off. The contents of catheter bags can be discarded according to local policy. Any wounds should be covered with an occlusive dressing. Drains must be left in place and bunged off but the drain bags can be emptied and discarded fluids carefully recorded	Any fluids discarded should be described for colour, turbidity and measured volume in the patient notes as part of the evidence and record.
If applicable, leave endotracheal (ET) tubes in situ. This is because cutting the tube deflates the balloon that holds the tube in position. Slacken off any ties to reduce pressure lines forming on the face.	The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through

Sensitively inform the family that, after the coroner's involvement, ET tubes or lines will be removed and they will then be able to spend time with the deceased. They can also do this at the funeral director's premises. Personal care can then be given as per deaths without coronial involvement.	post-mortem examination. Keeping family informed
Deaths without coronial involvement, **An expected adult death –**	
Assemble required equipment	To prevent interruption of the procedure once commenced
Using universal precautions, wash hands and put on gloves and apron and any PPE deemed necessary	Hand washing reduces the transmission of micro-organisms. Wearing protective clothing reduces the risk of contamination with body fluids in line with Trust infection policies.
Carry out all personal care of the patient after death in accordance with safe manual handling and infection prevention policies. Adopt universal precautions, and where indicated due to risk of infection adopt contact or respiratory precautions.	
Lay the patient flat on their back. Straighten their limbs with their arms lying by their sides. Leave one pillow under the head.	To maintain the patient's dignity and for future management of the body as rigor mortis occurs 2-6 hours after death. The pillow will support alignment and helps the mouth to stay closed. It can be removed before wrapping.
Wash patient. It may be important to family and carers to assist with washing, thereby continuing the care given to the patient in the period before death.	Prepare family for the changes to the body after death.
Gently close the eyes by applying light pressure for 30 seconds to the eyelids.	
If for corneal tissue donation place saline soaked gauze to keep eyes closed and protected.	Patient will need to be in mortuary within 2 hours to best preserve eyes for donation.
Do not tape directly to the skin.	Tape may mark the face.
Apply pad and pants to all patients.	There may be further urinary/faecal leakage after death.

Remove mechanical aids such as syringe drivers, applying occlusive waterproof dressings to sites and document disposal of medication that remained in syringe driver.	
Remove any cannula, endotracheal tubes. Remove drains and collection bottles pad around wounds and seal with an occlusive dressing. Cover stomas with a clean bag.	Prevent further bodily fluid leakage after death. Sites of blood cannulas will need a pressure dressing to reduce risk of leakage
Exuding wounds should be covered with absorbent dressing and secured with an occlusive dressing	The dressings will absorb any leakage from the wounds and provide protection for any staff coming into contact with the body.
Do not shave the person.	Shaving a deceased person when warm can cause bruising and marking which only appears days later
Clean the mouth using a moistened, soft, small headed toothbrush and/or suction to oral cavity to remove any debris and secretions	For hygienic and aesthetic reasons
Clean any dentures and replace them in the mouth – a small pillow placed under the patient's jaw may help to keep the jaw closed and the teeth in situ. (Remove it before family view the person.) If unable to replace dentures – place clean dentures in a denture pot labelled with patient ID and send to the mortuary with patient.	Dentures can be more easily put in at the mortuary/undertakers.
Tidy the hair and arrange in the preferred style.	
Put shroud on patient or leave in their own night-clothes, if requested by relatives.	We no longer suggest tying the wrist-tapes together to protect the hands as there has been one case of tissue damage resulting.
Identification The registered nurse in charge of the patient's care is to complete all documentation. After confirming the patient identification with the notes, Apply a PID patient identity label to every page of the ICADP (WR4888)	Notes do not go to the mortuary so these staff will not have access to the PID.

Apply 2 identity bracelets which have the PID label which includes the address of the patient and written on the ward location – one to the wrist and second to the opposing leg.	To ensure correct and easy identification of the body in the mortuary. Usually opposite limbs are used
Complete 2 WR240 Notice of Death forms. One is applied to the shroud/clothing and the other to the clear plastic envelope of the body bag.	This give indication of any items like jewellery, drains etc left on the deceased.
In all cases wrap lightly in a sheet, covering from head to feet and tape sparingly it in position.	To avoid damage to the body during transfer. Do not bind the sheet too tightly as it may cause disfigurement
Adhering to Trust Manual handling policy and guidelines, move the patient into a body bag and zip up. Using a patient identity label, threaded through to secure the zip end fastenings together. Remember to place the WR240 form in the plastic envelope of the body bag.	This should remain intact on admission to the mortuary and will be opened by mortuary staff during the checking in process
In all cases Ensure manual handling slide sheets are in place.	In readiness for safe transfer.
RN to make certain that the Integrated Care after death pathway ward area section is fully completed and signed for where relevant and that RN is available for handover to porters. RN calls porters requesting transfer of deceased to mortuary.	To avoid delays in transfer when porters arrive. RN requests transfer to Mortuary, avoiding euphemisms like “Rose Cottage” to support honesty conversations.
Handover to Porters Screen off the area where removal of the body will occur. RN to enter bed space and handover patient, confirming identity verbally and other need to know information eg denture pot with patient. ALX/WRH The Integrated Care after death pathway is to go with the patient to the mortuary. KTC, record the details of funeral directors, time of collection and place the pathway in the patient record.	Alexandra Hospital – Contact porters via switchboard – ext 44444 Worcestershire Royal Hospital – Contact porters via the helpdesk – ext 33333 – For privacy and dignity The pathway is completed by mortuary and bereavement staff after ward staff.

Porters/funeral director to transfer the body with dignity and respect and regard for manual handling regulations and infection risk protocol, into the appropriate concealment trolley or use of an X-cube.	Reminder following Datix- Staff need to be aware of environment and may need to raise height of bed/ inflate mattress if it has been deflated to aid ease and safety of transfer. X-cube to be used at the ALEX for bariatric patients.
Porters and RN to sign for handover of patient. Porters will complete transfer and admit patient into the mortuary admission record on arrival. They will transfer the patient into the fridge.	
After ticking off the care that they have completed, the Integrated care after death pathway is left in the mortuary.	See Appendix 4
Care after death of the adult patient when COVID-19 is confirmed or suspected. **WR5619** Verification and certification	Currently version 2 but as a live document will be updated and expended. Adhere to guidance in the latest version accessible on Key Documents site.
Inform the medical staff and site nursing Bleep holder of the patient's death.	
Ward nurse to document the death and record time of last breath sounds.	
Verification of death must be recorded in the patient's medical and nursing notes. The expected standard is verification within an hour of the patient's last breath sounds.	
All doctors can verify death. Those registered nurses who have successfully completed training and competencies in the Trust may verify an expected adult death.	See Appendix 3
Contact hospital bereavement office to inform them of the patient's death and they will collect the notes.– out of hours leave a discrete message on their answerphone.	If families wish to view a body once it has been transferred to the mortuary this can be organised during office hours by the Bereavement Office at the Alex and via Mortuary department at WRH. Out of hours viewings for hospital deaths can be organised on both sites on Saturdays, Sundays and Bank Holidays by contacting the site bleep holders, see WAHT-PAT-002.
If the patient has an implanted device such as a	

pacemaker/ICD – please record this fact on both Notice of death cards and pathway and whether the ICD has been deactivated.[6]	
Care in the Mortuary Mortuary staff will review the risk of transmissible infection/ disease and act according to the guidance. They will admit to the mortuary, and do checks re jewellery/valuables/belongings. They liaise with funeral directors when the body is released. They oversee pacemakers/prosthetic removals. They will schedule viewings.	.
Out of hours viewings. WAHT-PAT-002 Mortuary assistance with viewings OOH. : Procedure for Issuing a 'Medical Cause of Death' Certificate and Early Release of Deceased Patients.	
Fast release of bodies- see SOP	See Appendix 3
Bereavement office The bereavement office will ensure that the patient's GP is informed of the patient's death. Doctors will complete the MCCD (Medical certificate of Cause of death) and Medical examiners ME's will review and contact staff /families to support and clarify information especially when cremation forms are needed. ME out of hours contacts rota with Switchboard. Staff will liaise with the Register office sending MCCD electronically and the bereaved relatives regarding the processes.	This links to Early release flowchart Appendix 3
Kidderminster General Hospital. Wards have folders with all local funeral directors' services and contact details for relatives to choose. Staff need to have the conversation about choice of funeral director, pre-emptively where possible. Contact a funeral director according to relative's wishes.	KTC to inform patient's GP/ Duty GP who will certify. If an expected death once certified designated funeral directors can take from the ward. If for Coroner's investigation, GP will liaise with Coroner's office and funeral directors.

A contract has been awarded to a local funeral director to deliver services in the following situations - If the family have not made choice known and are nor contactable. -if Hospital are arranging the funeral as no identified next of kin - provide transport to WRH for PM for example. Funeral director services to be contacted if Coroner directs that the body is for removal. If property is left on the ward – staff must contact family and request collection **Death Occurring Outside of wards e.g Outpatient Department/Endoscopy/Theatres** If the deceased is an admitted in-patient follow care after death protocol, inform ward from where they came and ward staff may support with paperwork and care in the department. If the person is not an in-patient, then they should be taken to A&E.	

Viewing Arrangements once bodies have left the ward – Redditch/Worcester

Monitoring Tool

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Key parts- Keeping staff safe who handle body after death	Audit of Integrated Care Pathway for the Adult Patient After death WR4888	1 time a year	EOLC facilitators	Report to HIA EOLC Committee & Divisional Governance Committee	Annual report
	The body of a person who has died is cared for in a culturally sensitive and dignified manner. Nice QS 12 (13)	Recording and monitoring training attendance	Ongoing record sent to training	End of life care facilitators	Report to HIA EOLC Committee	Annual report

REFERENCES

1. Nursing & Midwifery Council. (**2018**). The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. www.nmc.org.uk *Accessed 18.10.2022*

2. Thompson-Hill, J & Mackleston, J session within e-ELCA *Introduction to Personal Care After Death 2.* (2012)

3. Dougherty, L; Lister, S (2008) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures.* 7th Edition Blackwell Publishing, Oxford.

4. *Guidance for staff responsible for care after death (last offices).* NHS Improving Quality and Nurse Consultant group (Palliative Care, 2011) www.hospiceuk.org

5. Department of Health & NEoLCP (2011) *When a patient dies – Advice on Developing Bereavement Services in the NHS*, Department of Health London.

6. BHF: ICD deactivation at the end of life: Principles and practice (2013) Dr James Beattie Consultant Cardiologist, Heart of England NHS Foundation Trust, https://www.bhf.org.uk/-/media/files/publications/hcps/icd-deactivation.pdf

7. Ministry of Justice Publication : *A guide to coroners and inquests* (2010)

One chance to get it right : improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People (2014).

APPENDIX 1

Referral to the Coroner

If the cause of death is known, is a natural cause, and a doctor has attended the deceased within 14 days prior to death, then a death certificate may be issued without referral of the death to the coroner.

The death should be referred to the coroner if:

- **the cause of death is not known**
- **there is no attending practitioner(s) or the attending practitioner(s) are unavailable within a prescribed period.**
- **the death may have been caused by violence, trauma or physical injury, whether intentional or otherwise.**
- **the death may have been caused by poisoning.**
- **the death may be the result of intentional self- harm.**
- **the death may be as a result of neglect or failure of care.**
- **the death may be related to a medical procedure or treatment.**
- **the death may be due to an injury or received in the course of employment, or industrial poisoning.**
- **the death occurred while the deceased was in custody or state detention, whatever the cause of death.**

The coroner has a judicial duty to enquire into those deaths reported to him. The coroner is concerned with:

- **The identity of the deceased**
- **When the deceased died**
- **Where the death occurred**
- **How the deceased came about their death**

Following referral to the coroner:

- **A death certificate may be issued after consultation**
- **The coroner may order a post mortem examination. If this confirms that death was due to natural causes, the coroner will issue a death certificate.**
- **If the post mortem examination reveals an unnatural cause, an inquest will be held.**

If a death is reported to the coroner and a post mortem examination is required:

- **All endo-tracheal tubes and catheters should remain in situ. Catheter bags may be removed and the catheter spigoted. Endo-tracheal tube ties should be cut and the tube may be cut short to rest within the mouth, but the cuff should remain inflated.**
- **Chest drains, surgical drains, epidural lines should also remain in situ. They can be disconnected, capped and then folded back and covered with an occlusive dressing.**

Special Consideration for suspicious deaths

If a person has died in suspicious circumstances and a police investigation is likely then the following procedure should be observed to preserve forensic evidence and minimize cross contamination:

- **The body should not be washed or cleaned, unless express permission has been given by the senior police officer in charge of the investigation or by the Coroner**
- **The body should not be touched by family and friends, unless express permission is given as above. The police will often allow supervised touching by the family.**
- **A catholic priest should be permitted to anoint the forehead and administer the sacrament of the last rights to a dying person, or the recently deceased. It would be rare for the police to refuse permission for this**
- **Clothing should only be removed after expressed permission from the police – if removed clothing and property (including cash and valuables) of the deceased should be listed as per Trust Policy, bagged and handed to the police if requested. A signature of receipt should be obtained from the police.**

Appendix 2

GUIDELINES FOR HANDLING CADAVERS NOT NOTIFIABLE INFECTIONS IN ENGLAND AND WALES

Degree of Risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
LOW	Acute encephalitis	No	Yes	Yes	Yes
	Leprosy	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
MEDIUM	Relapsing fever	**Advised**	Yes	Yes	Yes
	Food poisoning	No/**Advised**	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	Acute poliomyelitis	No	Yes	Yes *	Yes
	Diphtheria	**Advised**	Yes	Yes	Yes
	Dysentery	**Advised**	Yes	Yes	Yes
	Leptospirosis (Weil's Disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes *	Yes
	Meningococcal septicaemia (with or without meningitis)	**Advised**	Yes	Yes	Yes
	Paratyphoid fever	**Advised**	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Scarlet fever	**Advised**	Yes	Yes	Yes
	Tuberculosis	**Advised**	Yes	Yes	Yes
	Typhoid fever	**Advised**	Yes	Yes	Yes
	Typhus	**Advised**	No	No	No
HIGH	Hepatitis B, C	**Yes**	Yes	No	No
HIGH (rare)	Anthrax	**Advised**	No	No	No
	Plague	**Yes**	No	No	No
	Rabies	**Yes**	No	No	No
	Smallpox	**Yes**	No	No	No
	Viral haemorrhagic fever	**Yes**	No	No	No
	Yellow fever	**Yes**	No	No	No

DEFINITIONS – See over page

GUIDELINES FOR HANDLING CADAVERS WITH INFECTIONS NOT NOTIFIABLE

IN ENGLAND AND WALES

Degree of Risk	Infection	Bagging	Viewing	Embalming	Hygienic Preparation
LOW	Chickenpox/Shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Methicillin resistant Staphylococcus aureus (MRSA)	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Clostridium difficile (C diff)	No	Yes	Yes	Yes
MEDIUM	HIV/AIDS	**Advised**	Yes	No	No
	Haemorrhagic fever with renal syndrome	No	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
HIGH	Transmissible spongiform encephalopathies, eg Creutzfeldt–Jakob disease (CJD)	**Yes**	No **	No	No
	Invasive Group A Streptococcal infection	**Yes**	No	No	No

DEFINITIONS

* Requires particular care during embalming

** If necropsy has been carried out.

Advised = Advisable and may be required by local health regulations.

Bagging: placing the body in a plastic body bag

Viewing: allowing the bereaved to see, touch, and spend time with the body before disposal.

Embalming: injecting chemical preservatives into the body to slow the process of decay. Cosmetic work may be included.

Hygienic Preparation: cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming

Appendix 3- Flowchart of Early release Can the Doctor issue the Medical Certificate Cause of Death (MCCD)?

YES

The clinician will liaise with the ME (contacted through switchboard between 8-5 only) to discuss the completion of the MCCD. **NO MCCD is issued beforehand**.

The ward will inform the on-call mortuary technician that there is an early release pending.

The ME queries the Cause of Death

H.M. Coroner's Referral

Follow adjacent flow chart

The on-call mortuary technician will liaise with the registrar for an appointment following the issue of the MCCD.

Both sides of the original MCCD are to be scanned to out of hour's registrar via RegistrationCoronerf@worcestershire.gov.uk Email must also include; Clinician GMC number, NOK/nominated representative contact details and assigned undertakers

The Registrar will arrange a date and time with family to register the death. Once this has taken place, the registrar will inform the on-call mortuary technician.

Family/appointed FD are issued a Death Certificate & Green Disposal Form or White Disposal Form (Stillbirths). Appointed FD to liaise with on-call mortuary technician for a date & time of collection.

'Out of England Release'/Free from Infection certificate collected at a later date.

NO

The clinician refers the death to H.M. Coroner through the Coroner's Officers

Post Mortem required?

YES

No early release possible

NO

H.M. Coroner issues a Form A to accompany the MCCD (completed by the Doctor)

Early release possible without the death being registered as H.M.Coroner & Registrar has been informed.

Cremation

Cremation Forms need to be completed by 1st part clinician before release can go ahead. Disposal number to follow after the death is registered and disposal form evidenced to mortuary staff on collection. . (With the exception to 'Form A' being issued by H.M. Coroner).

Burial

Release can take place after the Funeral Director has been confirmed. Disposal number to follow after the death is registered and disposal forms evidenced to mortuary staff on collection. (With the exception to 'Form A' being issued by H.M. Coroner).

Appendix 4
CARE AFTER AN ADULT DEATH FLOWCHART

VERIFY TIME AND DATE OF DEATH OF PATIENT
CORRECTLY IDENTITY PATIENT & PLACE 1st COMPLETED

↓

COMPLETE
THE INTEGRATED CARE PATHWAY FOR PATIENT CARE AFTER DEATH FOR ADULTS (WR4888) OR IF COVID, CARE AFTER DEATH OF THE ADULT

↓

COMPLETE NOTICE OF DEATH CARD X 2
(WR420)
ONE CARD TO BE ATTACHED TO THE SHROUD/ PATIENT NIGHTWEAR
AND
ONE CARD TO BE INSERTED INTO THE BODY BAG CLEAR

↓

PORTER CALLED TO WARD

↓

ON ARRIVAL, PORTER **AND** REGISTERED NURSE TO:

CHECK IDENTIFICATION ON OUTSIDE OF BODY BAG AGAINST INTEGRATED CARE AFTER ADULT DEATH PATHWAY (WR4888). (WR 5619) REMAINS IN THE PATIENT CASENOTES ON THE WARD.
REGISTERED NURSE HANDS OVER CARE TO PORTERS BOTH COMPLETE WR488 HANDOVER SECTION AND SIGN

↓

ONCE THE ABOVE CHECKS HAVE TAKEN PLACE,
THE PATIENT CAN BE TRANSFERRED TO THE MORTUARY AND TAKES WR4888 WITH THEM, FOR MORTUARY STAFF TO COMPLETE AND THEN BEREAVEMENT STAFF TO COLLECT, COMPLETE & THEN RETURN TO PATIENT CASENOTES.

CONTRIBUTION LIST

Key individuals involved in developing the document

Name	Designation
Ann Carey	Director Nursing for Medicine Division
Tess Makinson	End of life Care Facilitator
Sheryl Thomas	Mortuary manager
Tim MacCormac	Mortuary manager
Julie Webb	Matron, Surgery
Kathryn Norwood	AMBER champion and staff nurse WRH

Circulated to the following individuals for comments

Name	Designation
Lisa Miruszenko	Deputy Chief Nurse
Pauline Spenceley	PALS manager
Jackie Littlejohn	Bereavement officer
Rani Virk	Privacy & Dignity
Deborah Narburgh	Matron
Lisa Walker	Ward manager Wd 5
Avril Adams	Lead Palliative & EOLC nurse
Alice Ferguson	EOLC facilitator
Palliative & EOLC Link workers	Trust wide
Dr Mandeep Uppal	Consultant Palliative care , Quality
Emma Fulloway	Infection Prevention & Control Nurse Manager
Elaine Stratford	Bereavement Nurse
Sheryl Thomas	Mortuary Manager

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Ann Carey	Medicine
Sarah King	Surgery
Hospital Specialist Palliative & EOLC team	Clinical Support

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Avril Adams	HIA EOLC Group
Tess Barley	Bereavement group membership
Tessa Mitchell	Privacy & Dignity Group
Amanda Moore	Haematology/Oncology Governance Group

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Age	no	
	Disability	no	
	Gender reassignment	no	
	Marriage and civil partnership	no	
	Pregnancy and maternity	no	
	Race	no	
	Religion or belief	no	
	Sex	no	
	Sexual orientation	no	
2.	**Is there any evidence that some groups are affected differently?**	no	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	no	
4.	**Is the impact of the policy/guidance likely to be negative?**	no	
5.	**If so can the impact be avoided?**	n/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	n/a	
7.	**Can we reduce the impact by taking different action?**	n/a	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	no
2.	Does the implementation of this document require additional revenue	no
3.	Does the implementation of this document require additional manpower	no
4.	Does the implementation of this document release any manpower costs through a change in practice	no
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	no
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval