Verification of Expected Death Guidance for Devon

Date:		1st January 2020	
Author:		Macmillan GP Facilitator, Western Locality, Devon CCG	
Supporting Executive(s)		Chief Nursing Officer, Devon CCG Associate Chief Nursing Officer, Devon CCG	
Supporting Executive Approval Date			
Administrative Support		EOL Project Manager, Devon CCG	
Purpose of Guidance		**Decision**	
		Assurance	✓
		Information	✓
FOI Status		**Public**	✓
		Private	
Category of Guidance		**Decision**	
		Position statement	
		Information	✓
Does this document place individuals at the centre?		**Y**	✓
Actions Requested		Members are asked to consider the information and approve the guidance to improve the quality of VOED in community settings	
Which other Committees has this item been to?		EOL STP Steering Group	

Reference to other documents	Further information & guidance can be accessed on the following sites: https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/clinical-resources
Have the legal implications been considered?	Yes
Does this report need escalating?	No

Equality Impact Assessment			
Who does the proposed piece of work affect?	Staff ✓ Patients ✓ Carers ✓ Public ✓		
		Yes	**No**
1.	Will the proposal have any impact on discrimination, equality of opportunity or relations between groups?		✓
2.	Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		✓
3.	Will there be a positive benefit to the users or workforce as a result of the proposed work?	✓	
4.	Will the users or workforce be disadvantaged as a result of the proposed work?		✓
5.	Will the users or workforce be disadvantaged as a result of the proposed work?		✓
If the answer to any of the above questions is yes (other than question 3) or you are unsure of your answers to any of the above, you should provide further information using **Screening Form One** *available from Corporate Services.*			
If an equality assessment is not required briefly explain why and provide evidence for the decision.			

Devon CCG has made every effort to ensure this guidance does not have the effective of discriminating directly or indirectly, against employees, patients,

contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

This guidance will apply equally to full and part time employees. Devon CCG guidance can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals of different nationalities who require them.

Reference to Core Strategies and Corporate Objectives

Core Strategies, we will:	Corporate Objectives	Does this report reference to the Core Strategies/ Corporate Objectives	
		✓	X
1. Take joint ownership with partners and the public for creating sustainable health and care services.	1.1 Develop people, and those who support them, to value strengths and personal qualities in all that they do.	✓	
	1.2 Listen to people and take action on what they say about services.	✓	
2. Implement systems that make the best use of valuable health resources, every time.	2.1 Innovate to increase productivity and reduce waste.	✓	
	2.2 Commission safe services and reduce avoidable harm.	✓	
3. Commission to prevent ill health, promote well-being and help people with long-term conditions to live well.	3.1 Support people to make healthy lifestyle choices and understand the care, treatment and services available to them.	✓	
	3.2 Commission services with partners to reduce health inequalities and improve people's lives.	✓	

Document Status:	Approval from Quality Committee
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DOCUMENT CHANGE HISTORY		
Version:	**Date:**	**Comments (i.e. viewed, or reviewed, amended, approved by person or Committee)**
1.0 (draft)	24.05.17	Task and Finish Group developed first draft version.
1.5 (draft)	09.06.19	Amendments/additions from group review and feedback.
2.0 (draft)	09.10.17	Amendments/additions CCG.
3.0 (draft)	16.11.17	Further amendments/additions with Devon VOED Education Providers' Group.
4.0 (draft)	18.12.17	Amendments/additions made by (LW) and (MM) during a consultation meeting on 18.12.17.
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5.1 (draft)	09.01.18	Amendments by LW.
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5.4 (draft)	26.06.18	Circulation to LW.
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7.0 (draft)	04.12.18	Amendments by MM.
8.0 (draft)	29.03.19	Amendments by JT and MM.
9.0 (for consultation)	25.04.19	Amendments by MM.
10.0	04.12.19	Amendments by MM following consultation with national Hospice UK team.
11.0	22/04/2020	Amendments by MM and JB following EOL STP discussions.

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Scrutinised by: (Name and Title): **Date:**	CHC and End of Life Programme Lead, Devon CCG Chief Nursing Officer and Caldicott Guardian, Devon CCG Head of Corporate Governance, Devon CCG
Document Reference:	VOED version 10.0 2020
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Executive Summary

The main purpose of the guidance is to provide a framework of information that can be referred to, often citing and signposting to organisational and national policy, for the timely verification of expected death by experienced healthcare professionals. It is important to note that the collection of documents offers guidance only.

In 2017, at the request of the STP End of Life Steering Group, work commenced to prepare over-arching guidance for those clinicians and organisations providing end of life care in community settings. The purpose of the work was to review current organisational and national policy and guidance and to invite contributions from a wide range of clinicians and managers across the whole of Devon. This process required continual review and revision, where drafts were produced and taken back to a working group for ongoing assessment and where possible shared with parties across the STP, whose advice and input were invaluable for updating and making the guidance as accurate and relevant as possible.

There are seven appendices including a summary of the names of the individuals and their organisations who have contributed to the VOED guidance.

The process for producing this guidance has been led by one of Devon's Macmillan GP Facilitators and project support in producing the documents has been provided by the CCGs, NEW Devon CCG and South Devon and Torbay CCG; and St Luke's Hospice.

VOED Guidance

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VOED Guidance

1. Introduction

Within any care setting, there will always be those patients/individuals whose death becomes inevitable. In applying this guidance, it should be remembered that dealing with the death of a patient in a caring, compassionate and professional manner is often the last service that can be provided for an individual and may ease the suffering of those who are bereaved.

The aim of this guidance is to provide a framework for the timely verification of expected adult deaths by experienced (i.e. assessed as competent) health care professionals. It will enable staff to care appropriately for the deceased, in line with local policy, and minimise distress for families and carers following an expected death at any time. It is in line with the person and family centred care recommended in national documents.

2. Definitions

2.1 Expected Death

A death following a period of illness which has been identified as terminal. Death is recognised as the expected outcome following discussions by the health care team, the patient if in a condition to express a view, the patient's relatives/close friends and it has been documented that no active intervention to prolong life is ongoing.

2.2 Verification of death

Verification of death is the procedure to confirm that death has occurred and that the patient is actually deceased.

2.3 Certification of death

Certification of death is the process of issue of the 'Medical Certificate of the Cause of Death' (MCCD) which is only completed by the medical practitioner involved in patient's care.

The act of verification and certification of death must be separated. If a death is expected, VOED can be performed even if it is not known at the time whether a patient's own GP is available to issue a MCCD. This is particularly relevant in the out of hours period.

2.4 Time of death

The official time of death is the time when verification of death is completed.

3. Purpose and Aim

3.1 To support registered healthcare professional staff undertaking VOED for adults.

3.2. Overarching guidance for all providers across Devon.

3.3 To ensure individuals, their families and carers are supported in the period immediately after death.

4. Scope

4.1 This guidance document covers expected deaths only in adults (aged 18 or over).

4.2 It is preferable that VOED is performed by a registered healthcare professional recognised by a professional body who has undertaken appropriate training and has been assessed as competent.

4.3 Registered nurses can verify deaths who require referral to coroner, if that death is expected and there are no suspicious circumstances. It is the responsibility of the doctor to make contact with the coroner.

4.4 VOED may be performed, in some circumstances, by a care assistant who is competent in clinical examinations. A minimum qualification of NVQ Level 3 is required before accessing VOED training. Where this has been discussed and agreed with the relevant NHS provider a plan for third party delegation can be used – see Appendix 2. There is no obligation for healthcare assistants to perform VOED.

4.5 This framework is provided to support all staff.

4.6 This guidance should be used to support VOED in both core and out of hours periods.

4.7 It covers deceased patients in their own home, or care setting and can be used to support VOED in nurse led community hospitals or hospices.

4.8 Where the deceased has a syringe pump or residual controlled drugs in situ, VOED should be undertaken by a registered healthcare professional.

4.9 Some providers may have additional or extended scope practice e.g. SWASFT.

4.10 Providers should follow their own policy for infection prevention and control and care after death.

5. Responsibilities

5.1 Clinical Commissioning Group (CCG)

It is the responsibility of Devon CCG to ensure that they commission services that are able to ensure timely verification and certification of death. The CCGs should also ensure they commission services that provide culturally sensitive and dignified care of the body after death and that they are supportive of commissioned services in the continuous improvement in the process around verification of expected death. The CCGs will also support and work with providers to ensure that training for the workforce is set up and available in order to deliver continuous and ongoing improvement around the process of verification of expected death.

The CCG will ensure that improvement processes are in place initially and will also review and instruct provider organisations with any changes and national guidance as it becomes available.

5.2 Providers

Have a responsibility to ensure their operational policy is fit for purpose and supports their staff in undertaking VOED.

Provider operational VOED policies and procedures should align with this guidance document.

In planning for VOED, processed should be in place to ensure patient and family involvement, full consideration of any cultural and/or spiritual needs and health and safety.

Written information should be provided/available for families.

The individual has been recognised as dying by a medical practitioner and this has been recorded in the care record.

All required supporting documentation is in place, that determines the death as expected and that the decision not to undertake resuscitation has been recorded and communicated.

A review by a medical practitioner within 28* days prior to date of death is required so that a Medical Certificate for Case of Death (MCCD) can be issued.

If the deceased has not been seen by their usual GP within the last 28* days prior to death and the death is expected with supporting DNACPR documentation, VOED may still be performed. This will require a discussion with a GP both in hours and out of hours. This includes a patient with a terminal diagnosis who has a sudden death, for example a pulmonary embolism.

*(Due to the COVID-19 pandemic this guidance has been reviewed and nationally amended to 28 days from 14 days. This is subject to review in line with the Coronavirus Act 2020).

5.3 **Best practice advises timely verification:**

- Community setting - within 4 hours of death.
- In-patient setting - within 1 hour of death.

5.4 **VOED by a registered health care professional SHOULD NOT be undertaken in the following;**

- In cases of sudden and unexpected deaths.
- When the patient is a child.
- If the death cannot readily be certified as being due to natural causes.
- There are any suspicious circumstances or history of violence.

5.5 Verification of expected death can still be performed if there is a reason to refer to the coroner, but you must inform the GP. Full list can be found here

5.6 If a Mesothelioma/Industrial disease diagnosis has been made, verification of death can be performed by a health care professional both in hours and out of hours after consultation with a GP - see appendix 6.

5.7 There may be times when staff may be unable to perform VOED. Reasons being:

- Course timings.
- Lack of observed VOED in clinical practice.

VOED should be performed in a timely manner and in these exceptional circumstances, may need to be performed by a GP. There should be no obligation on staff to perform VOED if they do not feel comfortable with the clinical situation.

Where a care home holds dual nursing and residential registration the registered health care professional, who is appropriately trained, competent available and employed by the home provider may undertake VOED for any expected death within that setting.

6. Coroner Information

6.1 From 1 April 2019, deaths are being referred where necessary electronically. Form E-95 should be completed electronically and emailed to the relevant coroner's office.

Exeter:	exetercoronersofficers@dc.police.uk
Barnstaple:	barnstaplecoronersofficers@dc.police.uk
Plymouth and Torbay:	plymouthcoronersofficers@dc.police.uk
Cornwall	cornwallcoronersofficers@dc.police.uk

6.2 For further advice the local Coroner Officers can be contacted:

Cornwall: The Lodge Penmount Newquay Road Truro Cornwall TR4 9AA Telephone: 01872 227191	**Exeter:** Devon County Hall Topsham Road Exeter EX2 4QD Telephone: 01392 225682
Barnstaple: Barnstaple Police Station North Walk Barnstaple EX31 1DU Telephone: 01271 311356	Plymouth, Torbay and South Devon: Derriford Business Park Plymouth Devon PL6 5QZ Telephone: 01752 487401

6.3 Out of hours death reporting contact: Devon and Cornwall Police via 101.

6.4 For more information about coroner's services:

www.plymouth.gov.uk/home/birthsmarriagesanddeaths/death/coroner

Ministry of Justice (2014). Guide to coroner services. Accessed: 28/03/19. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf

7. Training and Competence

7.1 Anyone undertaking VOED should have received relevant training by an approved training provider, be assessed as competent and partake in continual professional development.

7.2 Providers are responsible for ensuring staff have access to training.

7.3 Competency assessment should be recorded and regularly reviewed as part of the practitioner's professional development record. As a minimum, VOED should be discussed at annual appraisal and competency reassessment at a 3 yearly interval. See individual organisation's policy on frequency/timings for reassessment of competence.

7.4 Registered healthcare professionals are responsible within their professional code for ensuring fitness to practice.

7.5 Residential care home settings – see Appendix 2.

8. References

Ministry of Justice (2014) Guide to Coroner Services. Accessed 28 March 2019. Available at:

https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

Hospice UK (2019) Care After Death – Registered nurse verification of expected death (3rd edition). Accessed 4 December 2019. Available at:

https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/clinical-resources

National Council for Palliative Care (2015) Every Moment Counts: A Narrative for Person Centred Co-ordinated Care for people Near the End of Life. Accessed 28 March 2019. Available at:

https://www.nationalvoices.org.uk/publications/our-publications/every-moment-counts

Resus Council UK (2016) Decisions relating to Cardiopulmonary Resuscitation (3rd Edition – 1st Revision). Accessed 28 March 2019. Available at:

http://www.resus.org.uk/dnacpr/decisions-relating-to-cpr

BMA Confirmation and Certification of Death. Accessed 22/04/2020. Available at:

https://www.bma.org.uk/advice-and-support/covid-19/practical-guidance/covid-19-death-certification-and-cremation

9. Appendices

Appendix 1 - Competency Assessment Form for Verification of Expected Death (VOED)

COMPETENCY ASSESSMENT FOR VERTIFICATION OF EXPECTED DEATH (VOED)

Name:	
Name and Signature of Trainer:	
Training Provider:	
Date of Training:	
Date Observed Clinical Assessment:	
Name, Signature and Professional Qualification of Clinical Assessor:	

Guidance on Training/Competence:

- Anyone undertaking VOED should have received relevant training and been assessed as competent.
- Providers are responsible for ensuring staff have access to training.
- A clinical assessor can be any trained member of staff with competency in VOED.
- Competency assessment should be recorded and regularly reviewed as part of the practitioners PDR. As a minimum, VOED should be discussed at annual appraisal and competency reassessment at a 3 yearly interval. See individual organisation's policy on timings.
- Registered healthcare professionals are responsible within their professional code for ensuring fitness to practice.

In order to achieve competency, you must pass all standards below both in training and observed clinical practice.

	TRAINING		CLINICAL PRACTICE	
KNOWLEDGE OF:	**Pass**	**Fail**	**Pass**	**Fail**
Who can recognise a death?				
Who can verify a death?				
Who can certify a death?				
Definition of expected death.				
Definition of unexpected death.				
Definition of official time of death.				

	TRAINING		CLINICAL PRACTICE	
AWARENESS OF:	**Pass**	**Fail**	**Pass**	**Fail**
Indications for DNACPR: • Can refer to Resus Council Guidance.				
TEP/DNACPR document and correct documentation.				
When death needs to be referred to a coroner.				
When death requires referral to coroner but when verification may still be performed				

	TRAINING		CLINICAL PRACTICE	
EVIDENCE OF:	**Pass**	**Fail**	**Pass**	**Fail**
Correct identification of patient and clinical record.				
Knowledge of infections, implantable devices and radioactive implants identified from medical notes.				
Knowledge to instigate the process of deactivation of a device after VOED.				
Knowledge of universal infection control precautions.				

	TRAINING		CLINICAL PRACTICE	
PRACTICAL PROCEDURE OF VOED: **To determine that irreversible cardio-respiratory arrest has occurred, observation and examination with the following steps should take a minimum of 5 minutes before proceeding to pupil and trapezius examinations.**	**Pass**	**Fail**	**Pass**	**Fail**
Absence of carotid pulse after palpating for a minimum of one minute.				
Absence of heart sounds, determined by placing stethoscope in 2 places for a minimum of one minute.				
Absence of respiratory activity, determined by observation and listening to upper and lower lobe of each lung, with a stethoscope, for a minimum of one minute.				
Following these steps and if there is no return of cardio or respiratory activity after 5 minutes you can move on to pupillary and trapezius examination. **If there is any doubt or any spontaneous return of cardio-respiratory activity, a further 5 minutes observation is required.**				
Determine pupillary response by shining a torchlight into each eye and establish if pupils are fixed and dilated (by observing no change in pupillary shape or size).				

Perform trapezius squeeze to confirm absence of cerebral activity.				
Knowledge of what to do with tubes, lines, drains, patches and pumps				
	TRAINING		**CLINICAL PRACTICE**	
DOCUMENTATION IN CLINICAL NOTES:	**Pass**	**Fail**	**Pass**	**Fail**
Time of death.				
Local VOED death form.				
Name of witness.				

	TRAINING		**CLINICAL PRACTICE**	
UNDERSTANDS:	**Pass**	**Fail**	**Pass**	**Fail**
Emotional impact of bereavement on family, friends and residents, if residing in a care home.				
Confidentiality issues.				
How to offer support.				
The process after death documentation and administration and can signpost patient's relatives/friends/carers.				

Statement of Competency

I, …….

(Print name and designation) feel competent to perform VOED unsupervised.

Signed: …….. Date: ……

Appendix 2 - Residential Care Home Setting Guidance.

RESIDENTIAL CARE HOME SETTINGS

Where a residential home or domiciliary care provider wishes to undertake VOED they should:

- Be supported by NHS services to do so and a third party delegation framework should be applied.

- The registered manager will identify senior staff for whom training and competence assessment will be undertaken. Senior staff should all be trained and competent in performing clinical observations. A minimum qualification of NVQ Level 3 is required before accessing VOED training.

- Competency assessment should be recorded and regularly reviewed as part of the practitioners PDR. As a minimum, VOED should be discussed at annual appraisal and competency reassessment at a 3 yearly interval. See individual organisation's policy on timings.

- Access training and updates – as per organisation policy.

- Take responsibility and hold accountability for meeting requirements, guidance & legislation.

- Have an operational policy for VOED that supports those senior staff employed in their setting.

- Have discussed and agreed between provider services in advance that residential home/domiciliary care can undertake the procedure.

- CQC recommend where a care home holds dual nursing and residential registration the registered health care professional, who is appropriately trained, competent and employed by the home provider may undertake VOED for any expected death within that setting.

- Residential home/domiciliary care should have access to and engage with local end of life forums to ensure they maintain contemporary knowledge. This may be accessed through care home forums.

Appendix 3 - Referral Request Form for Verification of Expected Death (VOED).

REFERRAL REQUEST FORM FOR VERIFICATION OF EXPECTED DEATH (VOED)

The following questions should be asked by the healthcare staff or out of hours call handler receiving the referral/request for a nurse to undertake VOED and should be retained as part of the patient care record:

Patient Name:	
Address:	
NHS Number:	
Date of Referral:	
Time Referral Received:	

Triage Questions	Tick as required and add any additional comments
Is this confirmed as an expected death? **Tick to indicate how this has been confirmed.**	Yes ☐ No ☐ Note on Electronic Palliative Care Co-ordination System (EPACCS) ☐ GP Special Message/Fax ☐ Documented in clinical notes ☐ Documented in palliative care plan ☐ Do not attempt cardio-respiratory resus document (TEP) ☐ **If unable to confirm this is an expected death, do not undertake VOED. Refer back for GP to attend.**

Are there any known notifiable diseases, information control risk, radioactive implants or implantable medical devices?	Yes Details:	☐	No	☐
Are there any known implantable cardiac defibrillators (ICD) that require deactivation? **Note: VOED may still be performed by staff if ICD in situ.**	Yes Details:	☐	No	☐
Are the family/carers aware that a nurse will be verifying the death?	Yes Details:	☐	No	☐
Is the place of death the same as the address provided above?	Yes Details:	☐	No	☐
Name of Person making the request: Time informed: Contact number(s):				

Referral Outcome: Was this referral accepted based on responses to the above triage questions?	Yes ☐ No ☐ Details:

Full name of staff member receiving referral and undertaking referral acceptance questions:

Please Print:	
Nurse Signature:	
Designation:	

Appendix 4 - Form to Record Verification of Expended Death (VOED).

FORM TO RECORD VERIFICATION OF EXPECTED DEATH (VOED)

The patient has been identified to me as:

Patient Name:	
Date of Birth:	
Gender:	
NHS Number:	
Name of Own GP:	
Medical Practice:	

Asked to see patient at …… hours.

Attended at …….. hours.

Patient is known to primary care team? Yes ☐ No ☐

To determine that irreversible cardio-respiratory arrest has occurred, observation and examination with the following steps should take a minimum of 5 minutes before proceeding to pupil and trapezius examinations.	
Response	**Confirmed (Please tick)**
Absence of carotid pulse after palpation for a minimum of one minute.	
Absence of heart sounds, determined by placing stethoscope in 2 places for a minimum of one minute.	
Absence of respiratory activity determined by observation for a minimum of one minute.	
Absence of cardio-respiratory effort is observed over a minimum of 5 minutes (includes examination time above).	
Fixed, dilated pupils, which do not react to light.	
Trapezius squeeze to confirm absence of cerebral activity.	

If all the above are confirmed, you may complete the death verification form.

Death confirmed at: (time and date death verified)	

Place of death:	
Name of verifier:	
Signature:	
Role:	
Relative or carer present at time of death (full name)?	
Has Next of Kin been notified?	
Name of Next of Kin and relationship to deceased:	
Contact details:	

It is not mandatory to know the answers to the questions below, but this additional information will assist GPs in after death administration.

Any concerns expressed by family about care?	
Pacemaker or other implanted device in situ?	
Implantable defibrillator in situ? Deactivated?	
Are you aware of any recent falls?	
Are you aware of any operation in the last 12 months>	
Are you aware of any industrial disease exposure including asbestos?	
Does this patient have any additional cultural spiritual or religious needs?	
Is there anything else you think the GP should know?	
Person who has nursed the patient over recent days (name and contact details)?	

Appendix 5
Flow guide for verification of expected death (VOED) with no suspicious circumstances

NHS
Devon
Clinical Commissioning Group

Patient found deceased

Is there a "Do not attempt to resuscitate" in place?

No → Are there features of irreversible death present, e.g. rigor mortis?
See section 8 of the resus council's decisons relating to CPR guidance document.

- Are there features: **Yes** → Is death expected?
- Are there features: **No** → Commence CPR and call 999

Yes → Is death expected?

Is death expected?

- **No** → Call Own GP/Devon Doctors (if out of hours)
- **Yes** → Can you verify the death?

Can you verify the death?

- **No** → Call own GP or out of hours GP who may be able to assist you remotely to perform verification
- **Yes** → **Verify the death**

Verify the death

Call own GP or out of hours GP. Please be ready to share the following information from the questions below. You may not be able to answer all of these questions but information sharing will aid the GP in decisions relating to after death administration.

1. Who verified death?
2. What information is on the DNAR document (TEP)?
3. Who was present at the moment of death?
4. If there were persons present at the moment of death, did those persons have any concerns?
5. Who was nursing through last illness?
6. Any falls or injuries in the last year?
7. Next of kin contact details:
   - Are they aware?
   - Have they expressed concerns?
8. Any pacemaker or implanted device? Is it deactivated?
9. Any operations in the last year?
10. Any formal complaints regarding care?
11. Any suspicion of mesothelioma/industrial disease?
12. Was the patient discharged from hospital in last 24 hours? And was this discharge for end of life?
13. Is there any other reason known to refer this death to the coroner?

- **I have concerns** → Own GP will contact the Coroner and if out of hours Devon Doctors will make decision to contact Coroner via 101

  For suspicious deaths – Call Police
- **I have no concerns** → Notification to own GP

Mesothelioma: Sensitively inform family members that a post mortem may be needed and that the coroner will assess the situation during working hours. A post mortem is generally required if diagnostic biopsy has not been obtained or if the family wish to make a compensation claim.

Appendix 6 – Protocol for Registered Nurse Verification of Expected Death (VOED) of Patients with Mesothelioma in the Community Setting.

PROTOCOL FOR REGISTERED NURSE – VERIFICATION OF EXPECTED DEATH (VOED) OF PATIENTS WITH MESOTHELIOMA IN THE COMMUNITY SETTING

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1. Procedure for Normal Working Hours

1.1 Contact patient's GP Surgery or Devon Doctor, as appropriate, to inform of the death and establish the following:

- The Medical Practitioner is aware of the reportable diagnosis.
- The death will be reported to the Coroner's Office by the GP.
- Permission is obtained for nurse verification of the death.

Arrangements will be made for transfer of the patient's body to the premises of a local funeral director in accordance with the family's preference and choice.

2. Procedure for Out of Hours

2.1 Sensitively inform any family members/friends present that a post mortem may or may not be needed and that the Coroner will assess the situation on the following working day and advise as to whether or not a post mortem is required.

Contact the Devon Doctors Out of Hours GP Service and inform the operator of the following details:

- Patient's name.
- Date of birth.
- GP name and practice.
- Contact name for the Duty Devon Doctor to call back.
- The expected death of the patient with a diagnosis of mesothelioma.

Confirm the death directly with the Doctor On Call and establish the following details:

- Police attendance is not required.
- Permission for nurse to verify the death.
- The Coroner will be notified of the death by the patient's GP.

Following nurse verification ensure professional title and organisation are documented for the purpose of traceability for HM Coroner.

The procedure for personal care after death may be carried out and:

- An identity band must be attached to the patient's wrist denoting their name and date of birth.

- A notice to the funeral director must be placed on the body to request Coroners Officers are informed of the location of the patient.

- The patient's body transferred to the premises of a local funeral director in accordance with the family's preference and choice.

3. Coronial Guidance

3.1 The Coroner will open an investigation/inquest.

The Coroner may accept the cause of death if a diagnostic histological biopsy is confirmed.

The Coroner may accept a letter from the GP stating the following:

- Their involvement in the patient's care.

- Confirmation that biopsies have been taken.

- That they can confirm cause of death was due to (or as a consequence of) mesothelioma.

In certain circumstances a post mortem may be required. The Coroner's Officers will discuss his with the patient's next of kin.

3.2 **Note: A post mortem <u>will</u> be required in circumstances where:**

- Diagnostic biopsy has not been obtained.

- The family wish to make a fatal Mesothelioma compensation claim (even if the diagnosis is confirmed).

3.3 Where appropriate, inform the family that a member may be asked to identify the patient at the hospital mortuary.

3.4 A post mortem <u>will not</u> be required in circumstances where diagnosis is confirmed by biopsy and a compensation claim has been completed.

3.5 The Coroner's aim is to conclude the investigation or inquest within 6 months. If the cause of death is confirmed, the inquest conclusion would likely be returned as death due to industrial disease (Coroners and Justice Act 2009; HSE 2014).

In this situation, the coroner will inform the registrar who will proceed to register the death in the usual way.

The family should be advised that the Coroner's Officer will make contact to inform of the appropriate procedure for registration of the death.

4. Further Information

4.1 For further advice the local Coroner's Officers can be contacted:

Cornwall: The Lodge Penmount Newquay Road Truro Cornwall TR4 9AA Telephone: 01872 227191 cornwallcoronersofficers@dc.police.uk	**Exeter:** Devon County Hall Topsham Road Exeter EX2 4QD Telephone: 01392 225682 exetercoronersofficers@dc.police.uk
Barnstaple: Barnstaple Police Station North Walk Barnstaple EX31 1DU Telephone: 01271 311356 barnstaplecoronersofficers@dc.police.uk	Plymouth, Torbay and South Devon: Derriford Business Park Plymouth Devon PL6 5QZ Telephone: 01752 487401 plymouthcoronersofficers@dc.police.uk

4.2 Out of hours death reporting contact: Devon and Cornwall Police via 101.

4.3 For more information about coroner's services:

www.plymouth.gov.uk/home/birthsmarriagesanddeaths/death/coroner

Ministry of Justice (2014). Guide to coroner services. Accessed: 28/03/19. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf

5. References

BLF (2007) ASBESTOSIS An Unnatural death. A report into investigations of Mesothelioma death and their impact on bereaved families. British Lung Foundation. Available at www.blf.org.uk.

Health and Safety Executive (2014). Coroners Inquest. Accessed 22 March 2019. Available at:

http://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/investigation.htm

Statement on malignant Mesothelioma in the UK BTS (2007). British Thoracic Society Standards of Care Committee Thorax 2007;62;ii1-ii19. Accessed: 22 March 2019. Available at:

https://www.brit-thoracic.org.uk/document-library/clinical-information/mesothelioma/mesothelioma-statement-2007/

Hospice UK (2015) Care After Death: Guidance for Staff responsible for Care After Death (Second Edition). Accessed 28 March 2019. Available at:

https://www.hospiceuk.org/what-we-offer/clinical-and-care- support/clinical-resources

Appendix 7
Top tips for verification of expected death (VOED)

NHS
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Verification vs certification

Verification of death is different to certification. Medical certification of cause of death (MCCD) must only be carried out by a medically trained doctor. BMA Guidance aims to clarify this distinction.

The latest Hospice Care national guidance can be found here.

The RCGP and BMA have worked together to produce guidance supporting any staff to verify death remotely. They advise to follow your local pathway if available. More information on their remote verification protocol can be found here.

We advise that staff may perform remote verification when they have attended a training course (which may be online) and are yet to have a witnessed VOED in practice or if they do not feel confident in the skills required and there are no other trained and competent members of staff to witness VOED on site.

The process of VOED in respect of timings and procedure should be identical in both witnessed VOED on site or via video remotely to achieve competency. You may then witness other members of staff and support a greater available workforce to perform VOED.

When not to perform VOED

VOED should not be performed in cases of sudden and unexpected deaths, when the patient is a child, or if there are any suspicious circumstances.

Sometimes patients with a terminal illness can have a sudden death, e.g. pulmonary embolism. Even though the deceased may not have been been seen by their GP within the last 28 days, verification can still be performed if a DNACPR decision is in place.

Guidance will be updated in the future to align with any new coronial legislative change.

Mesothelioma

VOED in a patient with mesothelioma does not need to be performed by a doctor. It is the responsibility of the doctor to report and discuss the case with the coroner. Remember to inform the family and carers of this as a post-mortem may be required and, in some cases, this may involve police visiting and transporting the deceased to a hospital mortuary.

A flow guide is available which is especially useful in the out of hours period - see Appendix 5.

Who can perform VOED?

In 2016, CQC advised that any adult can perform VOED, if that person is suitably trained, and deemed competent. They must adhere to strict local policy. Across Devon, staff require a minimum NVQ level 3 and be proficient in clinical observations before attending training. But remember, there is no obligation for staff to perform VOED.

In order to be deemed competent, you must have at least one witnessed successful verification in practice.

If you are not competent in verification, please inform the doctor of this as soon as possible.

Care homes

CQC recommend where a care home holds dual nursing and residential registration the registered health care professional who is appropriately trained, competent, available and employed by the home provider may undertake VOED for any expected death within that setting.

It is advisable to issue an ID bracelet for the deceased.

When to perform VOED

Registered nurses can verify adult deaths who require a referral to the coroner, if that death is expected and there are no suspicious circumstances. It is the responsibilty of the doctor to discuss the details with the coroner. You can find reasons to report a death to the coroner here.

You must observe for no cardiorespiratory effort for a full 5 minutes before proceeding to check for motor response by performing a trapezius squeeze.

These tips address the recurring issues during the Devon wide VOED consultation process. Author: Mairead McIntyre, Macmillan GP Facilitator, Western Locality, Devon CCG – April 2020.

Quick Guide to After Death Administration

NHS
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MCCD

- COVID-19 is a natural, acceptable cause of death.
- A swab is not needed if COVID-19 is believed to the cause for death.
- COVID-19 cases should not be referred to the coroner unless there is another reason for doing so. Full list of reasons to refer can be found here.
- Any registered medical practitioner can sign an MCCD, even if the deceased was not attended during their last illness and not seen after death, provided that they are able to state the cause of death to the best of their knowledge and belief.
- If there was no attendance either within 28 days before death or after death, then the registrar would need to refer that to the coroner.
- Attendance before death can be visual (i.e. in person) or by video consultation; it cannot be audio only.
- Attendance after death must be in person.

Registration

- Death registration appointments will take place over the telephone. The Coronavirus Act also allow email transfer.
- If NOK is ill, a funeral director can act as the informant.
- A death must be registered in the registration district in which it occurs.
- Scan individual MCCDs direct to the register office, along with NOK name and telephone number, (please ask for consent for information sharing in line with GDPR).
- Email the office where the death occurred and state if the death has been reported to the coroner.

  Devon: srteign@devon.gov.uk
  Plymouth: regoff@plymouth.gov.uk
  Torbay: registrationdeaths@torbay.gov.uk

Verification

- HospiceUK special Covid-19 guidance accessible here.
- The RCGP and BMA have worked together to produce guidance supporting staff to verify deaths remotely. This will be especially useful if you have not had a witnessed VOED in practice or if you do not feel fully competent in the skills required. Please call the deceased patient's GP or out of hours GP to the discuss the death. More information on remote verification during Covid-19 can be found here.
- There is a change to order of examination to minimise contamination of equipment and pupillary response is checked earlier.
- Observe for no cardiorespiratory effort for a full 5 minutes before checking motor response with trapezius squeeze.
- If the deceased requires a referral to the coroner, you may still verify the death, if there are no suspicious circumstances.
- A fall before death does not stop you verifying death. If the fall caused death, a SIRI is required.
- Length of time that a medical practitioner must have attended the deceased (in person/video consult) before a referral to coroner is required is now 28 days.
- If rigor mortis is present and there is no DNACPR decision, you do not need to perform CPR but can proceed to verification.
- Appropriate PPE should be worn during verification and physical care after death. The latest guidance can be found here.
- Advise family that keepsakes e.g. lock of hair/rings must be offered and obtained before transfer of the deceased. These should be placed in a sealed plastic bag and families advised not to open for 7 days. For further information see RCGP guidance here.

Cremation

- Cremation Form 5 is suspended. Only one doctor is required to complete a cremation form (Form 4).
- You do not need to have seen the deceased.
- A medical practitioner should have attended the deceased (in person or video consult) within 28 days before death, or viewed the body after death. 'Viewed' means in person and not via video consult.

Key legislation changes of the Coronavirus Act can be found here.
The latest PPE guidance can be found here.

This guidance toolkit was designed and produced for NHS Devon CCG by

St Luke's Hospice Plymouth

NHS
Devon
Clinical Commissioning Group

I'm a registered medical practitioner. Can I write a **Medical Certificate** of **Cause of Death** for this patient?

Was the death of natural causes* and can you state cause of death to the best of your knowledge and beliefs?

Yes

Did a registered medical practitioner attend** within 28 days pre-mortem or after death?

Yes

Is that medical practitioner available?

Yes

Ask that medical practitioner to complete the MCCD.

No

You can issue an MCCD for this patient.
Be sure to ask the next of kin if you can share their name and contact details with the Register Office, then email the scanned MCCD (both sides) with these details to the Register Office in the area where the patient died.

Devon: srteign@devon.gov.uk
Torbay: registrationdeaths@torbay.gov.uk
Plymouth: regoff@plymouth.gov.uk

No

Telephone the Coroner's office and discuss, as you may still be able to issue a MCCD if the Coroner is happy to issue a Form 100A.

No

Report to the Coroner using usual processes.

*COVID-19 is a natural cause of death and can be used as a direct or underlying cause of death. It should be notified to PHE but doesn't need to be notified to the Coroner.

** Before death, both consultations in person and by video count as attendances, after death attendance must be in person.

CORONAVIRUS
PROTECT YOURSELF & OTHERS

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