PAN-LONDON RESPONSE TO EXPECTED AND UNEXPECTED DEATHS IN THE COMMUNITY

A MULTI-AGENCY GUIDANCE DOCUMENT

Contents:

1. Introduction and Purpose

This document has brought together current practice by NHS 111, the Metropolitan Police Service (MPS), London Ambulance Service (LAS) and other community based health care services in London when receiving a report of a death outside hospital that may be expected or unexpected. A programme of work to develop this document was undertaken during 2018/19, involving workshops and pathway mapping events attended by multiple stakeholders. In the light of changes to the law after the COVID-19 pandemic, practice has changed and these changes are reflected in this document.

The objective of this document is to provide clear pathways and guidance in the care of patients - both adults and children and young people (under the age of 18 years) - who die in London out of hospital, when the death is expected or unexpected. This is in order to provide a good and timely service 24/7 to patients, their families and bereaved parties, whilst also meeting any requirements of the Coroners in the London region. It is also recognised that there are likely to be local differences in Coronial jurisdictions - this document outlines the core principles of the process.

Delays and areas of confusion between the Metropolitan Police Service (MPS), London Ambulance Service (LAS), GPs and other health care teams in responding to possible/likely expected deaths (ED) can result in a poor service to families and lead to the inappropriate use of emergency services. It is likely that more cases than necessary are referred to the coroner, and unnecessary cardiopulmonary resuscitation attempts are made, which can also result in additional distress for relatives. Case studies have identified system failures that can mean expected deaths are considered as suspicious or unexpected, leading to the involvement of police, coroners, delays in transfer to funeral directors, distress to family and the subsequent unnecessary allocation of resources.

Clarity regarding the process following unexpected deaths is also needed to avoid unnecessary distress to families at this challenging time.

New policy and stronger guidance to frontline first responders and better digital record keeping by primary (GP) and palliative care teams can improve this. The innovations and new ways of working that were initiated during the COVID-19 pandemic streamlined and improved these processes and in turn public experience, but there is still the opportunity to clarify and improve further. Clear guidance to the public and care home staff as to what constitutes an expected vs unexpected death and the response that they can expect when reporting an expected death outlined in this document will improve the experience for relatives and emergency teams responding to these circumstances.

We have outlined below the responsibilities of each of the key team that might be involved when a patient dies. Each organisation will make a commitment to update their policies and procedures to reflect this document.

There may be occasions that fall outside of these circumstances. Please contact the Incident Duty Manager (IDM) who is internal to LAS and the MPS Command & Control (MET CC) Chief Inspector to discuss further (via Control).

2. General Practitioner (GP) and Community Nursing Services

What do they do?

A GP provides routine health care to patients in the community. Several GP Practices/Surgeries may be available to a person to provide such care depending on the address. Patients MUST register with a Practice in order to receive primary health care.

What happens when someone dies in London?

- If the patient is known by the GP practice, the death is an **expected** death and it occurs within normal working hours, the family can ring the GP Practice to inform them and to arrange verification of death. In most circumstances a GP will visit the patient and verify that death has occurred, although there are other *trained* practitioners who may be in attendance might be able to verify death (e.g. community nurses, ambulance clinicians).
- The community nursing service is often already involved in the care provided to the patient and family. They provide generalist palliative and end of life care and can access essential equipment and provide ongoing monitoring. This is particularly relevant when the patient has died, is not known to the Palliative Care Team (PCT), equipment needs to be collected and ongoing bereavement support arranged for the family.
- It is only the GP that cared for that patient during their last illness who will be able to write the Medical Certificate of Cause of Death (MCCD), which is a document that enables a deceased's family to register the death. This doctor must have seen the patient either in person or via video consultation within the last 28 days of his/her life OR seen the deceased after death.

How can other professionals access the service?

- They can contact the Practice by locating the number via MiDOS or NHS Choices (www.nhs.uk).

How can the public access the service?

- During normal working hours, via the Practice number.
- Out of hours, via 111.

What don't they do?

A GP cannot write an MCCD (see above) for a patient who has died **unexpectedly**, unless they are confident that they know the cause of death. The coroner will need to be contacted

to discuss further. The coroner may contact the GP to provide further details about the deceased medical history.

3. NHS 111/Integrated Urgent Care (IUC) Services, including OOH GP services

Some areas will have integrated urgent care services, which can be accessed via 111. These services include a multi-disciplinary team within the call centre that consists of GPs, paramedics, nurses and pharmacists. In other areas the 111 service will refer to a separate out of hours (OOH) GP service. The visiting service may be a doctor or a nurse.

What do they do?

- Available for urgent medical problems when the person's own GP surgery is unavailable and the person is unsure what to do. They provide telephone and video consultations and can also organise clinic appointments or home visits with GPs and Advanced Nurse Practitioners.
- The service is open 24 hrs a day, 7 days a week, all year round.
- Following a call to 111, a fully trained health advisor on the phone assesses the situation. This can result in the caller being:
    - Directed to local services
    - Referred to a clinician for a telephone assessment - such as a GP, Nurse, Paramedic or Pharmacist. If a GP needs to speak to the patient, or visit, then the call will be passed to the GP OOH telephone assessment pool for a GP to call the patient back to discuss their needs
    - Referred for a face to face appointment with a clinician
    - Given advice on how to obtain necessary medication
    - Given self-care advice.

What happens when someone dies in London?

- If someone is calling to say someone has died in London, there is a need to know if this was **an expected death** or **unexpected death**.
- If the death was **expected**, there is no qualified person on scene to verify death and the deceased's own GP is not available, the call will be passed to the out of hours GP service for a visit to verify the death but not to issue a MCCD. This may take between 2-6 hours depending on the circumstances and current workload of the OOH GP. The visit may be preceded by a telephone call to discuss the verification of death process.
- Out of hours GP services do not always have access to the patient's notes kept by their own GP.
- If a patient has an electronic care plan, the Health Advisor will be able to identify there is one present and ensure the call is passed to a clinician.

- Out of hours, GPs can access electronic records.
- If the death was **unexpected**, sudden and recent (i.e. the patient is unconscious but still warm or the collapse was witnessed and just occurred), CPR instructions will be provided and referral to the LAS for a potential cardiac arrest. The 111 Health Advisor will remain on the line until the first crew arrives.
- If the death was **unexpected** but appears to be beyond resuscitation, (e.g. the individual is obviously dead and there are no signs of recent life), it will be referred to the Police who will attend to investigate the circumstances and onward referral of the case to the coroner.
- The police will attend and investigate all unexpected deaths. A police officer may request to be connected to a clinician to arrange a home visit by the OOH GP for verification of death to take place. The home visit may be preceded by a phone call with a GP for some clarification questions.
- When police are in attendance they will investigate the matter to determine whether it is unexpected and suspicious.
- If a healthcare professional is concerned that the circumstances of a death may be suspicious, this must be brought to police attention.

<u>How can other professionals access the service?</u>

- There is a dedicated number for health care professionals to access the 111/IUC service.
- *5 = LAS Crews
- *6 = Care Homes
- *7 = Community Services i.e. district nurses.

<u>How can the public access the service?</u>

- Call 111 for a problem or concern that cannot wait until the Practice GP is open

<u>What don't they do?</u>

Out of hours, GP services cannot provide a Medical Certificate of Cause of Death (MCCD certificate). ***All death certification can only be done by a clinician who knew the deceased during their last illness such as the deceased's own GP or hospital specialist involved in their care.***

Please be aware that the nurse or doctor who attends the deceased to confirm death is unlikely to know the patient or family.

4. London Ambulance Service (LAS) 999 Services

What do they do?

- LAS aims to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible. This includes responding to major incidents.
- The aim is to convey patients in need of immediate treatment to an emergency department
- LAS also respond to less serious or life-threatening conditions by operating a 'hear and treat' or 'see and treat' response to keep people at home, if that is their best option.
- LAS will signpost people to the most appropriate place of care, if an ambulance is not required.

What happens when someone dies in London?

- When a call is made to 999 and, in response to the questions asked during the call, e.g. is the patient conscious and breathing, numerous resources (including specialist support), may be sent to the patient to undertake resuscitation.
- The primary focus of London Ambulance Service (LAS) is to save and preserve life. The ambulance service control room will automatically dispatch circa three ambulance resources/vehicles to a potential cardiac arrest. This is to ensure adequate staff are present to undertake an effective resuscitation attempt. In addition, the call may be passed to other agencies, such as the police, as they may have local units with a defibrillator who can attend more rapidly than the LAS. This ensures the most rapid response for a patient in cardiac arrest. The LAS may also task lay responders such as community first responders to assist if they are local.
- The LAS will respond to **expected** and **unexpected** deaths, where the patient has died recently and, in some cases, where the death has occurred some time previously. However, if another agency (e.g. MPS) arrives first and advises that the patient is beyond resuscitation (obviously deceased), LAS will not always attend expected deaths and relatives are encouraged to access their advised pathways as opposed to calling 999.
- For an unexpected death in **children and young people (under the age of 18 years)** (otherwise known as a SUDI/C) the LAS will convey the child to A&E in all circumstances unless the police senior officer advises they wish the child to remain on scene (due to crime scene considerations) OR either catastrophic injury / advanced decomposition has taken place.
- The 999 call may provide limited information. If it becomes clear during the call or on arrival that the patient has a life limiting illness and the death is expected, resuscitation attempts may not commence, or if they have, they may be stopped.
- LAS have access to electronic urgent care plans to confirm diagnosis and preferences, wishes and decisions for patients where a plan has been agreed and

created. This may not be possible to access prior to arrival if it is a solo responder. Their focus is arriving on scene and intervening as soon as possible. It is helpful if the family are able to provide prompt and timely information in relation to whether a DNACPR decision has been made and whether the death is expected. In some cases, the ambulance clinicians may initially undertake a resuscitation attempt before determining it is unsuccessful, whereby it may be terminated. This can be in a public or private location.

- The Police are unable to access electronic urgent care plans, so will depend on LAS to inform them of any care plans available and decisions made e.g. in relation to DNACPR. In these situations, LAS will take responsibility as the clinical lead.
- Ambulance clinicians will look for evidence to determine an **expected death** – e.g. end of life medication, advance care planning documentation, hospital notes/letters and can share decision making with other health care professionals and the police.
- Ambulance clinicians are able to verify a death. Where a death is **expected**, the ambulance crew will verify death and then advise the GP (during working hours), or request the family to contact the GP the next working day. The family can then arrange for Funeral Directors of their choice to attend. Where a death in **unexpected**, the ambulance crew will verify the death and request the police to attend, if not already on scene.
- For an expected death in **children and young people (under the age of 18 years)** there is likely to be a palliative care paediatric team on call for advice and support. There is also likely to be a care plan (paper or/and electronic), which will provide additional details. In exceptional circumstances if LAS are present, they may be able to assist with transfer of the deceased child to a children's hospice, if required. If LAS arrive and they have any suspicions or concerns regarding the death (even if the death is expected), they must contact the police immediately and ensure the deceased and surrounding environment is preserved in its current state.
- NB: there is a different process after death if the coroner is involved i.e. where the death is considered to be unexpected or suspicious. There may need to be arrangements made for the deceased to be taken to a coroner's mortuary. A coroner's officer will contact the family to make arrangements and explain the process, detailed elsewhere. **Please note**: the coroner's process will even apply where specific religious or cultural orders require disposal of the deceased within a specific time frame.

<u>How can other professionals access the service?</u>

- There is a dedicated number for health care professionals to access the 999 service – 0203 162 7525.

<u>How can the public access the service?</u>

- Call 999 for an emergency (life threatening)

What don't they do?

LAS MUST not be used routinely to verify a death. The LAS does not transport the deceased from scene, unless in an exceptional case such as the child process detailed above and always in conjunction with the police and follows a set process.

5. Metropolitan Police (MPS) 999 Services

What happens when someone dies in London?

- Like the LAS, the primary focus of the Metropolitan Police Service (MPS) is to save and preserve life. When 999 is called or when police officers on patrol come across a casualty, this is their first responsibility, using their emergency life support training. Marked police units are usually issued with a defibrillator. This means that if a 999 (ambulance) is called for a patient who has collapsed or may have died, the ambulance service control room will often pass this call to the police. Police with a defibrillator may arrive first.
- Police officers from the MPS also have a responsibility to attend and investigate all **unexpected deaths**. These are deaths where the deceased has died suddenly or without the cause being expected due to illness, or where the cause is unknown. This will include all cases where the death may be due to accident, apparent suicide, violent act, or a work-related death - and any other death that is not medically expected.
- The responsibility of police at all **unexpected deaths** is to conduct an investigation to determine whether the circumstances are suspicious, or not. This may be apparent, or require further investigation. If the circumstances are suspicious, there will also be a criminal investigation by the police.

Why do police attend some expected deaths?

- Police may be called to an **expected death** if someone has concerns over the circumstances of the death. If so the police will investigate the matter in the same way as an **unexpected death**.
- Police may be deployed to save life but if life cannot be saved, they may find that the situation could be an **expected death**. When officers are despatched, limited information may mean details about the patient's care is not known. This is something that police officers can try to establish through their initial investigation when on scene. They can request assistance from the ambulance crew to interpret evidence of an 'expected death' such as paperwork or medical items at the location as they are not clinicians. Police should ask Ambulance Service control to check whether there are electronic urgent care plans. Relevant headline information from this can assist the police officers to identify whether the death is expected. An officer may also confirm this by speaking to clinicians in attendance who should provide clear evidence of why the death was expected e.g. clinical records, advanced illness,

preparation of the family by a clinical team, presence of medications required near end of life for symptom control. In these circumstances, the family can arrange for Funeral Directors of their choice to attend, once the death has been verified.

- If there are no ambulance clinicians on scene, police can contact the patient's own GP (or 111 OOH) to request information about whether the deceased had a terminal illness.

What will police do in the case of an **unexpected** death?

- It is the responsibility of police to investigate the **unexpected** death and determine whether it is **unexpected** and not suspicious, **unexpected** and requires further investigation, or is suspicious.
- In most cases, the first police officers to arrive will be in uniform. These officers will conduct the initial investigation and relay their findings to a supervisor. The supervisor will consider whether the death is to be treated as non-suspicious, or requires further investigation. If further investigation is required, the supervisor will request that a detective attends the scene to further the investigation.
- In all cases that are non-suspicious the police will try and establish who has died, when they died, where they died and in what circumstances. The police must then report these findings without delay to the Coroner.
- Police will arrange for the deceased to be taken to the local public mortuary. A Funeral Director contracted by the local coroner will do this. The police will stay with the deceased until the Funeral Directors take the body (other than in the case of unexpected death of an under 18, where LAS will take the child to A&E).

How can other professionals access the service?

- The Ambulance service control room communicates with the police control room and police units via CAD and via dedicated phone numbers.
- Coroner's Officers can telephone a police control room resource desk and supervisor.
- A healthcare professional at the location of a death who needs to speak with the police can call 101.

How can the public access the service?

- 999 for an emergency (life threatening). 101 in a non-emergency situation

What don't they do?

- In some cases, a post-mortem examination will need to take place. This is a decision taken by the coroner, not by the police and is based on the overall circumstances. (See Glossary for Inquest details).
- If a family has any religious or cultural needs, they should tell the police officer about this. It is important to share any concerns the relatives have about treatment of the deceased or requirements for burial. The police officer can relay this information to

the coroner's officer, who will be experienced in answering questions. The coroner will make a decision about whether family needs, such as for speedy burial, can be fully accommodated.

- After the deceased has been taken to the public mortuary the case comes under the care of the coroner, who is entirely independent of the police. The coroner's officer will contact the family, usually the following day, to make arrangements and explain what will happen. If the police are still investigating, a police officer should also be in contact to update the family.

6. The Coroner

What do they do?

Coroners investigate the death of persons when there is reason to suspect that the cause of death was unnatural violent, unnatural, of cause unknown or occurred whilst the person was in prison or otherwise detained by the state. England and Wales are divided into geographic areas along county or local authority lines, which each has its own Senior Coroner responsible for investigating deaths that come under their jurisdiction in that area.

What happens when someone dies in London?

When a person dies, in order for that person to be buried or cremated, the registrar must be satisfied as to the cause of death and that it is natural, or that if arguably unnatural, sufficient investigation of that death has taken place. For natural deaths, the MCCD is usually sufficient for the registrar to approve burial or cremation by the issuing of a "green form" without which the funeral arrangements cannot proceed.

Any arguably unnatural deaths are referred to the coroner for further investigation. The coroner will then provide the necessary certification to the registrar and/or others for the burial or cremation when their investigative requirement is satisfied. This is described below.

Most coroners' cases are referred to them by doctors or the police service; others from concerned relatives or carers and prison governors.

If an unexpected death occurs, police, usually notified by the LAS, attend the scene on behalf of the coroner to exclude suspicious circumstances and other unnatural death. If there is any question that the death may have been unexpected or unnatural, they report the case to the coroner's service for further investigation. A specialist team of coroner's officers then investigates.

In many of these cases, the death will be natural, and the GP or hospital doctor will be able to issue an MCCD. This would be covered by the coroner issuing a form 100A to the registrar, to certify that the coroner is satisfied that no further investigation is required and that the death can be registered and move forward for funeral as a natural death.

In other cases, a post-mortem examination may be undertaken to try and establish the medical cause of death and how the person came to die. If this is reported by the pathologist as natural, and a medical cause is found, the coroner will issue a form 100B to the Registrar to allow registration of the death and the paperwork necessary for burial or cremation.

In some cases, further investigation or inquest may be required and undertaken by the coroner, for example toxicology, histology or statements from those who cared for the deceased prior to the death. Investigations may be discontinued if the death turns out to be of natural cause and there is no other reason to continue the investigation.

The coroner in all cases will release the body as soon as their forensic interest has been satisfied, with the paperwork to allow burial or cremation.

If a body is to be taken out of England and Wales, permission of the coroner must be sought and granted and will be given, if the coroner has no investigative interest in the death.

How can other professionals access the service?

Other professionals may access the Coroners service if they are also interested persons, for example if they may be involved with the inquiry. Far more commonly, the court will be relying on professionals to make referrals. Professionals may be asked by the court to provide statements or other evidence and attend court to appear as witnesses at an inquest. Coroners have wide-ranging powers to summon witnesses and evidence, and it should be fully unredacted.

Individual coroner's services each have advertised individual contact details. Many have websites.

Death reports are usually made by electronic forms, although telephone referrals may also be made, but should followed up in writing as soon as the referrer is able to.

How can the public access the services?

If they have concerns about a particular death, they should contact the coroner who covers the geographic area in which the body is laying via the coroner's published contact details. Many coroners advertise when inquests are to be heard on-line.

What don't they do?

Coroners do not investigate deaths that from the outset are not unnatural, nor do coroners investigate for speculative reasons. There must be some evidential basis for their jurisdiction to be engaged.

Deaths from industrial illness:

For the avoidance of family distress, where an expected community death from mesothelioma occurs outside working hours, there needs to be an arrangement between the on-call coroner's officer and funeral directors, in relation to removal and storage of the deceased.

7. Community Specialist Palliative Care (SPC) Services in London

What do they do?

- Each address in London has a Community Specialist Palliative Care (SPC) service that is commissioned by the NHS.
- These services are provided either by an NHS (acute or community) or hospice provider.
- The core hours of community SPC services are 0900-1700 Monday to Friday.
- Many SPC services also provide either telephone advice or a visiting service outside these core hours, but this is variable between services.
- Once referred to a community SPC service, patients will be given information about how to access the service within core hours, and how to access support outside core hours.
- **NB: Not all patients nearing the end of life will be / need to be seen by SPC services.**

What happens when someone dies in London?

- Community SPC services provide support for patients under their care who are reaching the end of their lives, and those important to them. This includes supporting family members about what to expect when the patient dies, and what to do after the patient dies.
- After a patient dies, members of the team will be able to provide support for the patient's family. A **Verification of death form** is usually completed by a GP or another suitably trained Health Care Professional available to visit soon after death (e.g. District / community nurse).
- The team may also inform the relevant health care practitioners/key health organisations of the death of a patient.
- In almost all circumstances, the patient's GP will provide the Medical Certificate of Cause of Death (MCCD) on the next working day.
- Special consideration may be extended to issuing an MCCD & consequent registration of the death out of normal working hours where specific religions / cultures require rapid disposal of deceased. This is **ONLY** if the coroner is not involved and only in exceptional circumstances.

How can other professionals access the services?

- LAS professionals – can find details of the local adult community SPC service through MiDOS.
- Other community-based health care professionals – should be aware of how to contact the local community SPC Service.
- Metropolitan Police Service – Other professionals at the scene will be able to provide contact details of the local community SPC service, or the local hospice is likely to be able to direct them to the relevant service.

How can the public access the service?

- Members of the public can request referral to their local community SPC service via their GP or hospital team.

What don't they do?

- SPC doctors may not be able to verify a death or provide a MCCD – please see above. This will differ between services and depend on involvement of the team.

8. Deaths in Care Homes

When making contact with healthcare services following the death of a resident it is essential to be clear with the provider you contact whether the death is **expected or unexpected**. This will be a standard question asked by both 111 and 999 service (see Glossary).

The only circumstances when it would not be appropriate to **verify a death** (requiring a registered health care professional to perform a set of observations to confirm there is no respiratory, circulatory or cerebral activity) is when a person's death was **unexpected or if** there is a belief that the **death was suspicious.** In these unusual circumstances, the MPS is contacted and the death would need to be referred to the coroner for further investigation.

An expected death is usually determined by prior conversations related to advance care planning (e.g. DNACPR decision made and preferred place of care determined).

- When accepting an admission to a care home on a Friday it is recommended to have a conversation with the hospital or hospice to clarify that there would be a doctor willing to provide an MCCD should the person die over the weekend, before the GP has had an opportunity to visit.
- Any registered nurses that are employed by a care home should be encouraged to undertake the verification of death training. This involves a 2 hour face to face training session with one supervised practice. This is invaluable in the provision of continuous care and support up to and after death for the resident and their family.
- The Registered Nurse Verification of Expected Adult Death guidance (RNVoEAD) is available on the Hospice UK website.

- If you have any suspicions or concerns regarding the death (even if the death is expected), you must contact the police immediately and ensure the deceased and surrounding environment is preserved in its current state.
- **Unexpected deaths** in a care home setting will still need to be investigated to ensure that there are no surrounding circumstances that could have contributed to the death, such as neglect, physical abuse or procedures not being conducted as required or policies not being adhered to.
- If the patient is at the venue against their will, for example – under a Mental Health Section, the investigation needs to take account of the patients' wider treatment and care. This type of death may result in a Coroner's Inquest and require a thorough police investigation.

9. Deaths in Prisons

All deaths that take place in prisons are treated as potential homicides. The police have the duty to make initial enquiries into the circumstances surrounding the death and must be given primacy for their investigation. This will ensure that other investigations do not prejudice any criminal investigation or the fair conduct of any legal proceedings that might result. It is the responsibility of the police and, when involved, the Crown Prosecution Service (CPS) to make sure that there is no prejudice to criminal proceedings.

The police investigation retains primacy over any investigation by other agencies, except in cases where the CPS advises there is insufficient evidence or it is not in the public interest to bring charges for a criminal offence, or the Senior Investigating Officer (SIO) decides a full criminal investigation is not required. A detective officer of the rank of Detective Sergeant or above and an Operational Forensic Manager will assess every death and make an initial assessment of the circumstances surrounding the death. They will liaise with the coroner as appropriate. When the circumstances of the death raise the suspicion of criminal conduct, a detective officer of the rank of inspector or above, or the SIO and a supervisory forensic investigator will attend the scene together and undertake an investigation.

Because the deceased has died in the care of the State this will always result in an Inquest at Coroner's Court, even when the death is not suspicious. The prison have responsibility to inform the Coroner of the death whether it is suspicious or not. However the police may take on this responsibility and liaise directly with the Coroner.

If the death is expected in either case the Prison staff should make police /LAS aware as soon as possible including details such as the presence of an end of life care/terminal condition and/or palliative care team involvement and any medical documentation such as electronic advance care planning documents and DNACPR decisions.

LAS Attendance

When LAS are called to attend a patient located within a prison, who is either in cardiac arrest or who deteriorates into cardiac arrest, they will follow their normal processes, including those associated with the termination of resuscitation, verification of death, and conveyance decisions. The location of the patient will not change the actions undertaken by LAS clinicians.

It is important in these circumstances for LAS clinicians to gain timely access to the patient, and to any health documentation held for that patient.

10. Deaths in Mental Health (MH) Institutions

It is likely for these calls, that an LAS officer will also be dispatched to the call. This is to assist with the management of the incident, not specifically about the clinical care provision. This is due to the potential complexity of the situation due to the location and access / exit from the site.

When making contact with services following the death of a MH patient it is essential to be clear with the provider you contact (LAS or Police) whether the death is **expected or unexpected** (see Glossary). If the death is expected this should be made clear to the call handler, providing details such as the presence of an end of life care/terminal condition and/or palliative care team involvement and any medical documentation such as advance care planning documents, Universal Care Plan and DNACPR decisions.

Where a person was not expected to die or if there is a belief that the death was suspicious then police must be informed immediately and they will initiate an investigation. All deaths in mental health institutions need to be referred to the coroner for further investigation. Where police are not involved the clinician will refer the death to the Coroner.

LAS Attendance

When LAS are called to attend a patient located within a mental health institution, who is either in cardiac arrest or who deteriorates into cardiac arrest, they will follow their normal processes, including those associated with the termination of resuscitation, verification of death, and conveyance decisions. The location of the patient will not change the actions undertaken by LAS clinicians.

It is important in these circumstances for LAS clinicians to gain timely access to the patient, and to any health documentation held for that patient.

11. Deaths of children – particular considerations

Several key national publications, outline the essential processes and considerations that are required following the death of a child.
The cause of death for most children who die is understood and the doctor who attends the child at the end of their life will be able to issue a MCCD and the death will be able to be registered.

If the death is from external causes, the circumstances are unclear, or safeguarding concerns or problems with care or service delivered are suspected, further investigations will be needed to understand how the child has died. If the child's death is sudden/unexpected and occurs outside hospital, LAS and the police will be called and a multi-agency process initiated in line with guidance.
There are a number of key considerations following a death of a child in the community. These include:

- ensuring the early involvement of the local Child Death Overview Panel, CDOP (for any death under 18 years) to provide support and allow timely investigation
- Being aware that support can be provided by the local hospital &/or CDOP team
- Ensuring safeguarding of other siblings & children
- Ensuring access to appropriate bereavement support for parents & siblings
- Being aware that ambulance teams will take a child's body to A&E at hospital unless there is a clear reason why this is not indicated - e.g. an expected death in a child who is receiving palliative care.

12. Deaths of people with a learning difficulty and autistic people

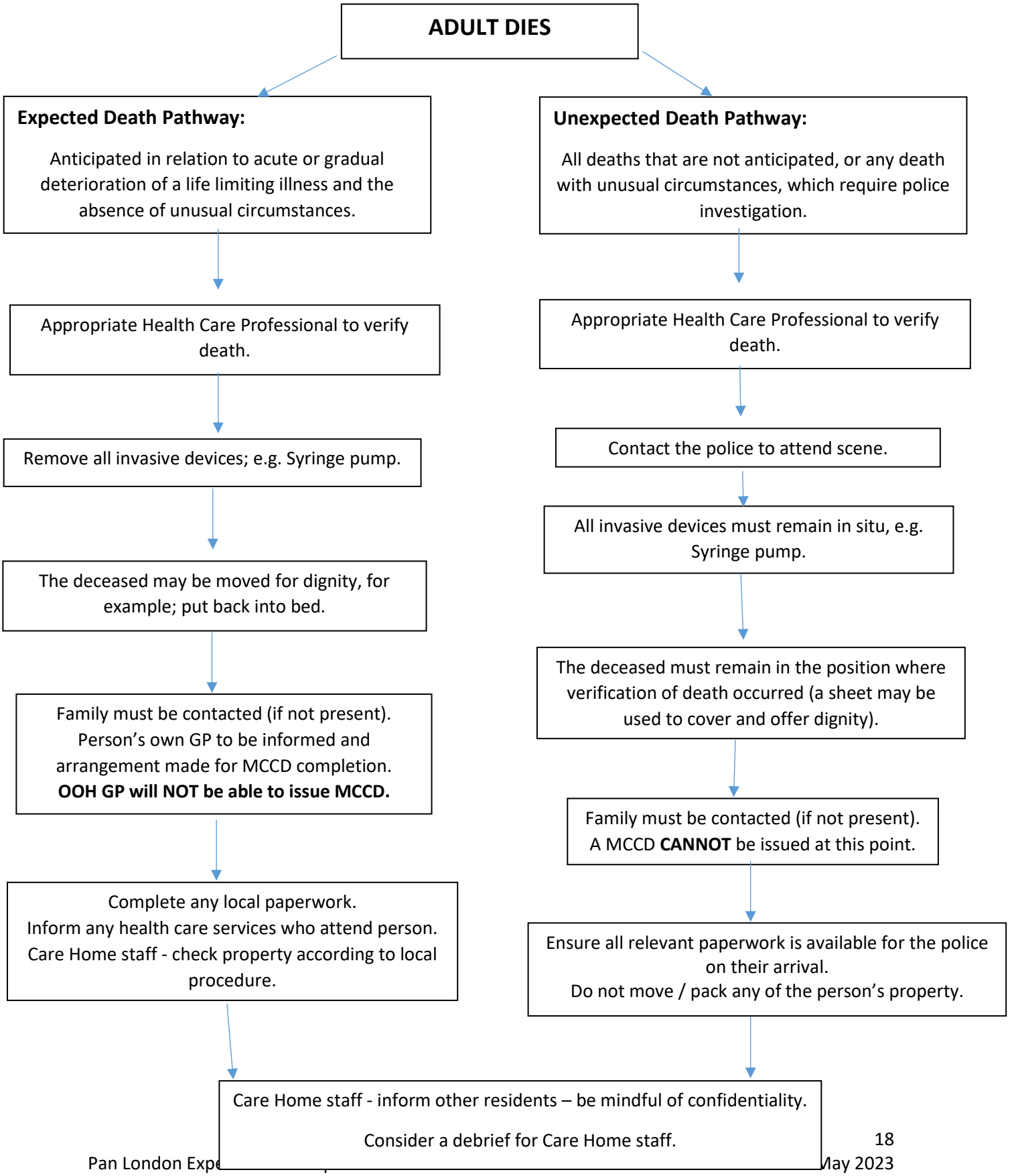
The NHS policy on 'Learning from Lives and Deaths - People with a learning difficulty and autistic people' (LeDeR) recommends that details about the deaths of anyone who was over 18 and autistic or who had a learning difficulty and was over the age of four should be reported using this process.

13. The National Medical Examiner

The NHS Medical Examiner system was set up to provide improved safeguards for the public by ensuring greater scrutiny of all non-coronial deaths, to ensure the appropriate direction of deaths to the coroner, to provide a better service for the bereaved and an opportunity for them to raise any concerns, and to improve the quality of death certification and of mortality data. The service is delivered by a Medical Examiner office, currently located within acute Trusts throughout England and Wales.

In 2020-21, a plan for the Medical Examiner system to include all non-coronial deaths in all settings was initiated. In London this is being developed at a variable pace by the current Medical Examiner offices. As the out of hospital based system develops, Medical Examiners will be working with primary care colleagues to support the process of death certification and to liaise with the family of the person who has died.

14: Care After Death Pathway (Adults)



15: References and support materials

Guide from home office confirming who can certify and who can confirm death: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757010/guidance-for-doctors-completing-medical-certificates-of-cause-of-death.pdf

Information about how to register a death at the Gov.uk website: www.gov.uk/register-a-death

16: Glossary of terms

Certification of death - the process of a doctor providing an MCCD to confirm the cause of death. Any doctor who has seen the person within their last illness can provide the certificate – this may be the doctor from the hospital or hospice where the person was transferred from, if they have recently been admitted to the home. If no doctor has seen the person, a discussion with the coroner's officers is needed. This does not necessarily mean the deceased will require further investigation.

Do Not Attempt CardioPulmonary Resuscitation (DNACPR) decision - Cardiopulmonary Resuscitation (CPR) is a potential treatment for anyone whose heart or breathing stops. It is defined as the provision of 'basic' and 'advanced' life support and includes attempts to ventilate the lungs, external chest compressions, high-voltage electric shocks and injection of drugs.

When a person is coming to the end of their life due to an advanced, irreversible illness (e.g. advanced cancer, severe frailty, end stage heart failure), there may have been a clinical decision made, in collaboration with the patient and their family, that resuscitation, in the event of cardiac (heart) or respiratory (lungs) arrest, would not be in their best interests. This might happen because a patient is so unwell from that underlying illness, that CPR will not prevent their death. By making the decision on behalf and with the patient and their family, there is an opportunity for the patient to have a peaceful, dignified death.

Having a DNACPR decision **does not imply** that any other aspect of monitoring, care or treatment will or will not be provided. All other appropriate care and treatment should be considered and given if appropriate. It is a decision made about one aspect of treatment and **does not imply** that the patient is expected to die.

The DNACPR decision may be documented on a form or on an electronic record called the Universal Care plan (UCP) which health care professionals will be able to access.

Expected death – this is as a result of an acute or gradual deterioration in a patient's health status, usually due to advanced, progressive, incurable disease. The death is anticipated, expected and predicted. It is anticipated in these circumstances that advance care planning and the consideration of DNACPR will have taken place. It can also be the case that a sudden event happens, which may still be an expected death (e.g. blood clot in a patient with lung disease). Details in an advance care plan provides clarity in these circumstances.

Inquest: The coroner will open an inquest in the following situations**:**

- Violent or unnatural
- Sudden and of unknown cause
- In prison, police custody or detained under the MHA
- Suspected to be suicide

An inquest is simply a court hearing of the evidence collected in a particular case designed to answer specific statutory questions. At the end of the Inquest the coroner, and in appropriate cases the jury, will complete a Record of Inquest recording their answers to the statutory questions, who was the person who has died and how, when and where the death occurred and the medical cause of death. If it can be argued that a state agency has failed in its duty to uphold an individual's right to life, the circumstances in which the death occurred will also be recorded. Inquests are heard in public and families are interested persons, entitled to disclosure, to ask questions of witnesses and make legal submissions to the coroner.

For murders, manslaughters, and cases subject to public inquiry under the Public Inquiries Act, the coroner will order post-mortem examination as required, open inquests then adjourn until the other agencies have completed their work. The coroner will then usually close the inquest unless wider matters not looked at by the Inquiry or Crown Court need further scrutiny, for example the mental health care provided to a person who committed manslaughter whilst acting under a schizophrenic delusion.

Records of Inquests are public documents and as such will be provided by the coroner on request.

Suspicious death – Where the death was not expected. Police have attended and carried out an investigation. Investigations are unable to confirm that there was no third party involvement and further investigation is required, or where in all likelihood there is third party involvement, or there is obvious evidence of homicide.

Unexpected death – this is when the death is not anticipated or related to a period of illness that has been defined as terminal. It will include all cases where the death may be due to accident, apparent suicide, violent act, or is a work-related death. When the death is completely unexpected and the healthcare professional is present, there is a requirement to begin resuscitation.

Verification of death - the process involving a registered health care professional performing a set of observations to ascertain there is no respiratory, circulatory or cerebral activity and therefore the person is deceased.

17: Contributors

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