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CONFIRMATION OF AN EXPECTED/ UNEXPECTED DEATH POLICY

1. INTRODUCTION

This policy and associated guidance is concerned with the process to be followed by healthcare professionals when confirming death of an adult. All expected deaths may be confirmed by any suitably trained healthcare professional e.g. Doctor, Paramedic, Registered Nurse and Midwife. The requirement to have a policy for undertaking the confirmation of death has arisen due to a general lack of clarity and understanding with regard to the Doctors role in confirming death, and changes in the General Practitioner contract / and European Working Time Directive which has resulted in General Practitioners / Hospital Based Doctors no longer being responsible or able to provide this service in a timely manner.

In April 1999 the General Practitioner's Committee (GPC) of the British Medical Association published guidance for general practitioners on confirmation of death (Appendix 1). This included advice that there was no requirement, either legally or under the NHS Terms of Service, for a general practitioner /responsible medical practitioner to confirm the fact of death. The GPC Guidance was issued to inform general practitioners of their obligations and also good practice. Its rapid dissemination was necessary because of changes in the organisation of general practice, especially out of hours, which make it increasingly likely that a doctor called to confirm death may not be the patient's own doctor. Because of this the confirmation of death and its certification have become separated. This guidance recognises that it is unlikely that any useful purpose will be served by an 'on call' doctor attending. This is particularly true where they are not known to the family and will not play any part in the ongoing care of the family.

NMC Guidance, issued in 2012 –states that in the event of a death, a Registered Nurse may confirm or verify death has occurred, providing there is an explicit local protocol in place to allow such an action nurses undertaking this responsibility must only do so providing they have received appropriate education and training, and have been assessed as competent.

Recognition of life extinct by ambulance clinicians is highlighted in 'Cardiac Arrest and Arrhythmias' (2006) and Services are encouraged, in conjunction with their coroner's service, to develop a local procedure for handling the body once death has been confirmed by ambulance personnel

4. TERMINOLOGY

Confirmation & Certification - Confirmation of death is the procedure of determining

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whether a patient is actually deceased. All deaths should be subject to professional confirmation that life has ended (Secretary of State for the Home Department, 2003). Confirmation can be undertaken by a medical practitioner or a suitably qualified health care professional. It is separate to the *certification* process which is an obligation on the doctor who attended the deceased during his or her last illness. *Certification of Death* can only be carried out by a medical practitioner or a coroner. Certification of death is to establish cause of death.

Expected Death - A death where the patient was expected to die or their friends or family had been informed was terminally ill or likely to die where there is a Do not attempt resuscitation order in place (DNA CPR Welsh Government Policy 2017) . These are usually determined by the fact that the patients own GP / responsible medical practitioner will be able to complete a certification of death. If the expected death is precipitated by an unexpected incident such as a fall or accidental harm a GP or responsible medical practitioner may be required to attend the deceased.

Unexpected Death - A death where there was no expectation that the patient was terminally ill or likely to die. This should include *suspicious death*, where there is suspicion or signs of violence, accident, poisoning or suicide or *unexplained death* where there is insufficient evidence available to assist in determining the likely cause of death.

5. WHO CAN CONFIRM DEATH

All suitably trained nurses, midwives and paramedics, following formal training in undertaking confirmation of death, can confirm death in their working environment. The procedure to be followed by nurses midwives and paramedics who work within the Health Board and are appropriately trained is outlined in Appendices 2 & 3.

6. TRAINING

A training package has been developed within the PCIC Clinical Board – moving forward all Clinical Boards across the Health Board will either adapt the developed training package and provide in-house training / or / will be able to access the training via the PCIC Education Team.

Training in the confirmation of death should as a minimum cover the following:

- An understanding of the legal implications and requirements;
- The procedure to follow when confirming death (Appendix 3);
- Clarification of the differences between certification and confirmation;

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- Explanation of Health Board Policy
- Clarification of expected death and unexpected death;
- The procedures for expected, unexpected, suspicious and unexplained death;
- Documentation of the fact of death;
- Awareness of related health board policies & procedures;
- The role of the Funeral Director;
- The role of the Coroner;
- Contacting the Police.

Training will include a half day theory supported by supervised competency based assessment (appendix 4). Competency will be assessed by a health care professional who is competent and confident to confirm death. Time frame to achieve competence is dependent on individual's confidence and not a pre- determined number of assessments. **Two signatures will be required on**

Confirmation of death form until an individual's competency has been achieved. Individuals must recognise their responsibility to work within limits of own competence and keep skills and knowledge up to date to maintain competence and performance.

The Registered Nurse / Paramedic should also be aware of the legal issues and related accountability to this extended scope of professional practice (RCN / HCPC).

7. DOCUMENTATION ON THE FACT OF DEATH

A legible, signed entry must be made in the patients record indicating the time and date that death was confirmed. Additionally a form indicating that confirmation of death has occurred must be completed (Appendix 5) and kept with the patient record. This form should clearly state full name of health care professional who has confirmed death (required for cremation form 4). This form may be required by HM Coroner should the responsible doctor find that they are in fact unable to complete certification of death. Healthcare professional (nurses midwives and paramedics) should also ensure all necessary documentation is completed as per Health Board policies & procedures.

8. ACTION TO BE TAKEN FOLLOWING CONFIRMATION OF DEATH

Expected Deaths - All deaths may be confirmed by any suitably trained health professional, e.g. a doctor, paramedic, a registered nurse or midwife working in the hospital, primary and community setting, community hospital or a nursing home – 'in and

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out of hours'. When a patient is expected to die, it is good practice for the healthcare professional that is caring for the patient to discuss with the patient's doctor who will be the most appropriate person to confirm death. This should be recorded within patient's medical records / documents.

The action to be taken in this circumstance is as follows:

- Confirm Death (appendix 2 +5);
- Advise relatives/carers that the patient has died and give information on what to do after a death;

If 'in hours' contact the Responsible Doctor / General Practitioner:

- advise that the patient has died;
- ascertain arrangements for certification;
- ascertain whether doctor / GP intends to visit before removal of body;
- advise those present of the outcome of these discussions.

If 'o u t of hours' it is the responsibility of the person who confirms the death to ensure the patients responsible doctor / GP is informed of the death on the next day (by phone).

If the responsible doctor / GP is not attending before the removal of the body, advise the ward or care home staff /relatives that they can transfer the body to the Mortuary or contact undertaker for removal of body.

On no account should a body be moved until a trained person has confirmed that death has occurred.

Medical certification of death can take place in the mortuary; however, there is no legal requirement for a GP/ responsible medical practitioner to see the body to certify death (appendix 1).

9. EXPECTED DEATH WHERE THE CORONER NEEDS TO BE INFORMED

The Coroner usually needs to be informed if the death is due to industrial disease such as Mesothelioma or asbestos related disease. Also if there has been an accident of any kind in the final illness. For a comprehensive list of deaths that should be reported to HM Coroner refer to Appendix 6.

Primary and Community Setting:

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If the death is expected but HM Coroner needs to be informed because an inquest is required then the Police will have to attend, e.g. someone dying following an injury received after a fall. In these cases the death will be reported to HM Coroner by the Police, once a qualified person has confirmed the death (Police Officers are not qualified to confirm deaths).

If out of hours the Coroner's office should be contacted through the police station and the situation discussed – for an unexpected death that is suspicious phone 999 (NB this may be classed as a crime scene), for an unexpected death that is not suspicious phone 101.

Hospital Setting:

Sometimes it is necessary to report a death to the Coroner before the medical certificate of cause of death can be given. Some of the circumstances include where:

- the cause of death is unknown;
- the cause of death is unnatural e.g. possible suicide, homicide, neglect, accident (including road traffic collision and inpatient incidents) or poisoning;
- death occurred within 24 hours of admission to hospital, during or after surgery or a medical procedure;
- death occurred during or immediately after detention in police custody.

The Coroner will decide either that:

- a post-mortem examination does not need to take place, in which case they will notify the Registrar of this, using a Form A and a death certificate will be issued; or
- a post-mortem examination will need to take place, in which case they will instruct a Pathologist (a highly trained doctor) to perform this.

After a post-mortem examination has been carried out, the Coroner will decide either that:

- no further action is necessary, in which case they will notify the registrar of this, using a form B: or
- that they need to hold an inquest; in which case, the coroner's officer will tell you of what happens next.

A coroner's post-mortem is a legal obligation and not subject to the permission of the deceased's family. If there is time to organise it in advance, relatives may be represented at the examination by their own doctor.

10. SUDDEN, VIOLENT OR UNEXPECTED DEATH – SIGNS OF SUSPICIOUS / UNEXPLAINED DEATH

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Where death is unexpected and where no explicit advance decision has been made about the appropriateness or otherwise of attempting cardiopulmonary resuscitation prior to a patient suffering cardiopulmonary arrest, and the expressed wishes of the patient are unknown and cannot be ascertained, it is presumed that healthcare professionals will make all reasonable efforts to resuscitate the patient and in community an emergency ambulance will be called.

However, it is possible in these circumstances to identify patients in whom there is absolutely no prospect of survival, and where an attempt at cardiopulmonary resuscitation would be futile. In such cases it would not be in the patients' best interest to commence Cardiopulmonary Resuscitation. In these circumstances it would be appropriate to perform confirmation of death. In these circumstances a Cardiopulmonary Arrest Audit form must be completed.

Healthcare professionals (nurses midwives and paramedics) should proceed with confirmation of death and if not a suspicious death bodies can be transferred to mortuary/undertaker.

11. CONDITIONS UNEQUIVOCALLY ASSOCIATED WITH DEATH

The conditions listed below are unequivocally associated with death in all age groups and cardiopulmonary resuscitation should not be attempted. If a relative or carer insists on cardiopulmonary resuscitation, careful explanation of the circumstances and the reason for not undertaking cardiopulmonary resuscitation should be given.

Hypostasis: the pooling of blood in congested vessels in the dependent part of the body in the position in which it lies after death. Initially hypostatic staining may appear as small round patches looking rather like bruises but later these coalesce to merge as the familiar pattern. Above the hypostatic engorgement there is obvious pallor of the skin. The presence of hypostasis is diagnosis of death- the appearance is not present in a living person.

Rigor mortis: the stiffness occurring after death from the post mortem breakdown of enzymes in muscle fibres. Rigor mortis occurs first in the small muscles of the face, next in the arms and then in the legs (30 minutes to 3 hours).

If called upon to confirm a death and the healthcare professional has any cause for concern, or observes anything untoward the following action should be taken if resuscitation is not to be undertaken.

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

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- Advise the relatives/carers of the action taken explaining that the police have been called and they will deal with further information.

If 'in hours' also contact the responsible doctor / GP:

- advise that the patient has died and that the police have been contacted;
- ascertain whether responsible doctor /general practitioner intends to visit;
- advise those present of the outcome of these discussions.

Complete all documentation and, if safe to do so, remain at the scene with the body until the police arrive - aiding preservation of the scene and ensuring continuity of evidence.

In these circumstances healthcare professionals must inform their line manager of the situation and ensure an adverse incident form is completed to capture the circumstances of the event as per the policy.

12. THE ROLE OF THE RESPONSIBLE DOCTOR / GENERAL PRACTITIONER

The responsible doctor / general practitioner will at all times consider the needs of living persons and these include the relatives, carers of the deceased as well as other patients. If the responsible doctor / general practitioner will be the Certifying doctor it is good practice to arrange to see the deceased as soon as practicable.

This need not delay the removal of body to the mortuary /undertaker. Where the certifying doctor is not available another doctor should assess whether a visit is needed to meet the needs of living patients (e.g. bereaved relatives).

13. GUIDANCE FOR OUT OF HOURS ORGANISATIONAL / DEPUTY DOCTOR

If a deputy general practitioner or out of hours organisation is contacted about a death an assessment should be carried out to decide whether a visit is appropriate. The deputy doctor will not be the certifying doctor and is unlikely to have any connection with the relatives or any access to the medical records. A visit will be appropriate when:

- There is no other health care professional competent to undertake the procedure for the confirmation of death.
- There is uncertainty about the fact of death.
- The needs of living patients (e.g. bereaved relatives) are required to be met.

14. BEST PRACTICE GUIDANCE FOR STAFF CARING FOR THE TERMINALLY ILL

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When a death is anticipated it is helpful if clear information is given to relatives/carers with regard to what action to take when a death occurs either in or out of hours.

Where it is appropriate, it is good practice to discuss and document 'Do not cardiopulmonary resuscitate' issues as part of advanced care planning. (See Cardiff and Vale University Health Board Do Not Attempt to Cardiopulmonary Resuscitate Policy – <http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/251418>).

Additionally when a death is anticipated and the patients preferred place of care is at home it is important that the out of hour's doctor service is informed of this fact by the Primary Health Care Team.

Postholders/ Groups/Organisations Consulted	Date Consulted/ Rationale for not Consulting	Comments Received: Y/N
Executive Directors*	√	
Clinical Board Medical Directors*	√	Y
Clinical Board Directors of Nursing*	√	Y
Clinical Board Managers – Head of Operations*	Clinical practice issue	N
Staff Representatives*	No Staff side issues identified through the stakeholder engagement	N
Appropriate Subject Committee/Group(s) (please specify)	NMB October 2018	Y
Relevant Professional Group(s) / Subject Specialist(s) (please specify)	DON, Lead and Senior Nurses, Resus Officer	Y
Service User Representatives/ Stakeholder Groups (please specify)	2018	Y
Third Sector/Partner Organisations (please specify)	2018	Y

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Other (please specify)

16. EQUALITY HEALTH IMPACT ASSESSMENT

Following assessment, this procedure is **not** felt to be discriminatory or detrimental in any way with regard to the following equality strands:

Gender; Race; Disability; Age; Sexual Orientation; Religion or Belief; Welsh Language or Human Rights (Appendix 9)

17. IMPLEMENTATION OF THE POLICY

Each Clinical board is responsible for their implementation of this policy. This Policy will be posted on the UHB Intranet.

18. PUBLICATION AND DISSEMINATION

The primary source for dissemination of this document - 'Confirmation of an Expected Death' - within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

19. CONCLUSION

E.g. The approval of the Confirmation of an Expected Death Policy will promote quality of care provision to the deceased and bereaved by promoting consistent approach to the confirmation of death procedures across Cardiff and Vale UHB – in and out of hours

20. RECOMMENDATION

The Board is asked to:

- **APPROVE** the "Confirmation of an Expected Death Policy"

Policy Commitment

What is the UHB committing to do and briefly indicate how?

The aim of the document 'Confirmation of an Expected Death' is to ensure that:-

- Quality of care provision to the deceased and bereaved by promoting a consistent approach to the confirmation of death procedures across Cardiff and Vale UHB.
- Staff who undertake the procedure are trained and competent

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The expected outcomes of this policy are as follows:

- For the death of the patient to be dealt with in a timely, sensitive and caring manner;
- The death is dealt with in accordance with the law;
- The Registered Nurse / Midwife / Paramedic skills and competencies are used appropriately;
- The distress of relatives can be reduced by having parenteral medication devices disconnected promptly and appropriately following the death of a patient, once confirmation of death has been established;
- All religious and cultural needs of the patient will be clearly identified and recorded in the patients nursing documentation prior to death.

Supporting Procedures and Written Control Documents

This Policy and the supporting procedures [*insert document title if only one otherwise say 'supporting procedures'*] describe the following with regard to [*insert Policy Subject*].

Appendix 1 – Guidance for GPs in England and Wales Confirmation and Certification of Death

GENERAL PRACTITIONERS COMMITTEE

1. INTRODUCTION

This guidance aims to clarify the distinction between confirming and certifying death in relation to GP's obligations.

English law:

- *does not* require a doctor to confirm death has occurred or that "life is extinct";
- *does not* require a doctor to view the body of a deceased person;
- *does not* require a doctor to report the fact that death has occurred;
- *does* require the doctor who attended the deceased during the last illness to issue a certificate detailing the cause of death.

(i) Expected deaths of patients

If the death occurs in the patient's own home, it is wise to visit as soon as the urgent needs of living patients permit.

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If the death occurs in a residential or nursing home and the GP who attended the patient during the last illness is available, it is sensible for him/her to attend when practicable and issue a death certificate.

If an 'on-call' doctor is on duty, whether in or out of hours, it is unlikely that any useful purpose will be served by that doctor attending.

In such cases we recommend that the GP advises the home to contact the undertaker if they wish the body to be removed and ensures that the GP with whom the patient was registered is notified as soon as practicable.

(ii) Unexpected ('sudden') deaths

If death occurs in the patient's home, or in a residential or nursing home, we recommend a visit by the GP with whom the patient was registered to examine the body and confirm death, although this is not a statutory requirement. The GP should then report the death to the coroner (usually through the local police).

In any other circumstances, the request to attend is likely to have come from the police or ambulance service. It is usually wise, and especially in the case of an "on-call" doctor to decline to attend and advise that the services of a retained police surgeon be obtained by the caller.

2. LEGAL REQUIREMENTS

The law requires a doctor to notify the cause of death of any patient whom he/she has attended during that patient's last illness to the Registrar of Births and Deaths. The doctor is required to notify the cause of death as a certificate, on a form prescribed, stating to the best of his/her knowledge and belief, the cause of death. It should be noted that the strict interpretation of the law is that the doctor shall notify the cause of death, not the fact. Thus, a doctor does not certify that death has occurred, only what in his/her opinion was the cause, assuming that death has taken place. Arising out of this interpretation there is no obligation on the doctor even to see, let alone examine the body before issuing the certificate.

The Broderick report recommended that a doctor should be required to inspect the body of a deceased person before issuing the certificate but this recommendation has never been implemented. Thus there is no requirement in English law for a general practitioner or any other registered medical practitioner to see or examine the body of a person who is said to be dead.

General practitioners as a body would not, and as individuals should not, seek to use this quirk of English law to avoid attending upon an apparently deceased patient for whom the GP is responsible. However, the fact that there is no legal obligation upon a GP to

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attend a corpse should be remembered and if necessary, quoted when organisations such as the emergency services ask general practitioners either in or out of hours, to attend a corpse as a matter of urgency. If a patient is declared to be dead a relative, a member of staff in a nursing home, ambulance personnel or the police, GPs would be right to explain that the needs of the living must take priority over the requirements of the dead.

On a parallel basis, case law exists to confirm that a NHS general practitioner does not have a contractual obligation to attend upon the body of a patient declared to be dead. Once again the fact that a contractual obligation does not exist should never be used by GPs to avoid the ethical and moral responsibility to make the experience of bereavement as gentle and easy as possible for relatives and friends.

3. SUDDEN OR UNEXPECTED DEATHS

These fall into two main categories:

- i. deaths where there is prima facie evidence of violence or other unnatural causes, including deaths in road traffic accidents, falls from high places, suicides and those apparently involving criminal violence; and
- ii. sudden or unexpected death where there is no prima facie evidence of violence or unnatural causes.

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

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

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

- i. A call from a relative carer or a nursing or residential home, about a registered patient who has been found to be dead, unexpectedly, but apparently in circumstances which are not suspicious.

The doctor should respond as quickly as the urgent needs of their living patients permit.

On arrival the doctor should carry out an adequate examination to confirm death and then consider whether HM Coroner should be informed. In all but very exceptional circumstances, even where there appear to be no suspicious circumstances, the doctor

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would be wise to notify HM Coroner. The GP should be mindful of the considerable distress this may cause to relatives, carers and friends and explain why the police will attend and the likely course of events subsequent to the attendance of the police.

- ii. A request from the police, or ambulance service that the GP attend upon a body found in a public place, a deserted building or as the result of a road or other form of accident or other situation.

In these circumstances there is no obligation upon the GP to attend. Under paragraph 4 (1) (h) (iii) of the terms of service, a NHS GP is required to provide treatment to persons not registered but requiring immediate treatment due to an accident or other emergency only if "he is available to provide such treatment". If the request is to attend upon a dead person or persons there is no question of a GP being requested to provide treatment, therefore there is no obligation to attend.

If the request is to attend to treat a person as a result of an accident it may be that the GP, whether the call is in working hours or out of working hours, is available and considers it would not endanger the other patients for whom he/she is responsible to attend the emergency. It would then be right and reasonable for the doctor to attend.

However, if the doctor is on call and dealing with numerous calls as when on duty for a co-operative or dealing with patients attending a surgery session, then it is reasonable to give a reply which indicates that the doctor is not available to provide such treatment.

If the police request a GP to attend a sudden death, unless that doctor is trained and experienced in clinical forensic medicine and the police offer the appropriate fee for the service, then the GP would be well advised to refuse to attend and advise the police to obtain the services of a retained police surgeon. If the request comes from the ambulance service then the response should be to advise the ambulance service that a doctor is not available and suggest that they ask the police to enlist the services of a retained police surgeon.

4. EXPECTED DEATHS AT HOME OR IN NURSING OR RESIDENTIAL HOMES

Calls during normal working hours

A doctor who has been treating the patient during their current illness should indicate that he/she will attend as soon as the urgent needs of any living patients have been satisfied. The doctor should then attend to confirm death and issue the Medical Certificate of Cause of Death. If the doctor who has been treating the patient is not immediately available, a colleague should attend and then ensure that the doctor of the deceased patient is informed of the death as soon as possible.

Calls out of hours

The likelihood is that the doctor on call is not the doctor who has been attending the deceased person during their last illness, and cannot therefore initiate the death certification process. If the death is in a nursing or residential home it is unlikely that any

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useful purpose can be served by a duty doctor attending during the out of hours period unless there is a genuine doubt as to whether the person is dead.

The obligation upon the on-call doctor or the co-operative, in those circumstances, is to ensure that the deceased's registered GP is notified at the first possible opportunity in the next period of normal working hours. It is then the responsibility of the doctor with whom the deceased was registered to deal with the death certification procedure. If the home so requests, normally undertakers will remove the deceased under these circumstances. Circumstances are similar if the person has died at home but, on those occasions, it may well be that there is a distressed relative, carer or friend who reasonably requires the attention of the doctor. If, however, the relative, carer is content to make arrangements with an undertaker, without the doctor attending, then there is certainly no need for a duty doctor to attend.

Within the hospital setting it has to be the treating doctor who writes the medical certificate certifying death.

6. PROBLEM SITUATIONS

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

Appendix 2 – Confirmation of Death by a Healthcare Professional

INTRODUCTION

This policy is for the confirmation of death by a healthcare professional (nurse midwife or paramedic) employed within Cardiff and Vale University Health Board, who as part of their role, may be required to confirm death. Training must be undertaken in the use of this protocol and the healthcare professional deemed to be competent before they undertake this expansion to their role.

CONFIRMATION OF DEATH

CONFIRM THE PATIENT IS UNRESPONSIVE	<ul style="list-style-type: none"> • Check that there is no response to a painful stimulus
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CONFIRM THE ABSENCE OF BREATHING	<ul style="list-style-type: none"> • Look at the chest for signs of movement for at least one minute • Check for the absence of breath sounds with a stethoscope for at least 1 minute
CONFIRM ABSENCE OF CIRCULATION	<ul style="list-style-type: none"> • Inspect patient for any signs of circulation (e.g. movement, pallor) • Palpate the carotid pulse for 1 minute • Listen for the absence of heart sounds – at least 1 minute
PUPIL REACTION	<ul style="list-style-type: none"> • With a bright source of light (i.e. pen torch) shine torch in each eye • Observe that both pupils are fixed

If there are no signs of respiration, no heart sounds and pupils are un-reactive – death can be confirmed.

It is not uncommon for there to be occasional spontaneous gasping sounds or occasional intermittent audible heart sounds soon after death and if this is the case the patient should be left for 15 minutes and the full procedure repeated.

Appendix 3 – Procedure for Confirming Death

Procedure for confirmation of expected death by a Registered Nurse / Paramedic

- Ensure all nursing staff / paramedic are aware of expected death i.e. record within care plan / care pathway;
- Following expected death of patient. Ensure the appropriate equipment is available:
 - 1) Stethoscope;
 - 2) Torchlight / pen torch / ophthalmoscope;
 - 3) Sharps box for disposal of parenteral / subcutaneous medication administration equipment.
- Check for clinical signs of death over a 5minute period, using a stethoscope and penlight. The following are recognised clinical signs used for confirmation of death, all the signs should be apparent before death is confirmed and recorded on

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the relevant paperwork.

- 1) Unresponsive and there are no vital signs of life e.g. movement, coughing, swallowing, for over one minute;
 - 2) Absence of carotid pulse over one minute;
 - 3) Absence of heart sounds over one minute using stethoscope;
 - 4) Absence of respiratory movement and breath sounds over one minute;
 - 5) Fixed, dilated pupils (unresponsive to pen torch) in both eyes;
 - 6) No response to painful stimuli, verified by application of pressure to nail bed for 10 seconds;
 - 7) Any spontaneous return of cardiac or respiratory activity during the period of observation should prompt a further 5 minute observation from the next point of cardio-respiratory arrest.
- Record the clinical observations within nursing notes / using template (see appendix 2):
 - 1) The date of death;
 - 2) The time of death (ascertained if necessary from relative / carer);
 - 3) Identity of any person present at the death or, if the deceased was alone, the person who found the body;
 - 4) Time of confirmation;
 - 5) Place of death;
 - 6) Clinical signs of death (listed above);
 - 7) Name of Doctor informing, time and date this took place;
 - 8) Signature of Nurse / Paramedic confirming death with the printed name of The Nurse underneath signature and designation.
 - 9) Contact family / next of kin, if not present;
 - 10) Perform laying out duties, if required and contact Funeral Director.

The record of the nurse / paramedic confirmation of death should be communicated to the patients GP as soon as possible following death by telephone message, secure fax or email

If this is an expected death, the nurse / paramedic should advise the relatives that the patient's own Doctor will be able to issue a medical certificate of the cause of death within 24 hours of the patient death, except at weekends or bank holidays when the certificate should be made available the next working day.

Primary Care Death:

If a death occurs during the OOH period, weekend or bank holiday and the deceased requires burial within 24 hours for cultural reason – families of the bereaved are advised to contact their local religious leaders for guidance on the process.

Hospital Death:

If the death occurs at the weekend /over the bank holiday period and the deceased requires burial within 24 hours for cultural reasons an information pack is available at the Bereavement Office offering guidance for medical / nursing staff regarding completing the medical certificate of cause of death/registering the death and release of the body.

If cremation is required a separate form (4&5) needs to be completed by

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medical staff.

The next of kin / relatives taking care of the funeral arrangements are required to phone the Bereavement Office the next working day to make arrangements to collect the medical certificate of cause of death. Not all certificates are issued from the hospital e.g. if the death has been reported to the Coroner and a Coroner's post mortem examination is taking place then there will be no certificate issued from the hospital. The Coroner's Officers will issue the relevant paperwork to the relatives.

NB. Parental drug administration equipment should be removed after the confirmation of death.

Appendix 4 – Confirmation of Death Competency Assessment

Practitioners name

Assessors name

DATE

TIME

No.	Criteria	Practitioner Signature	Assessor Signature	Comments
1	Professional is able to identify risks associated with the confirmation of death and actions			
2	Professional is able to describe the difference between the confirmation and the certification of			
3	Professional is able to describe when it would be appropriate to move the body to the mortuary or			
4	Professional is able to state the factors that would classify the death as expected or unexpected and action			

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5	Professional is able to state the unequivocal			
6	Applies appropriate painful stimuli and assesses response to confirm that there			
7	Visually confirms the absence of breathing movement. Using a stethoscope demonstrates appropriate auscultation			
8	Confirms the absence of circulation by demonstrating competence in palpation of the carotid pulse, cardiac auscultation (one min) with a			
9	Using an appropriate light source, Demonstrate the correct technique in ensuring that pupils are			
10	Is able state the correct action/procedure required if any signs of life are found			
11	Is able to state the correct action in relation to dealing with any IV medications during			
12	Professional is able to list the indications required for notification			
13	Professional is aware of other relevant LHB policy (such as last offices, cremation procedure,			
14	Professionals are able to identify any ICD / pacemaker / medical device on the body and can demonstrate a			

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15	Professional has demonstrated throughout confirmation of death compassion and Dignity for patient /			
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Professional must recognise and work within limits of own competence and keep skills and knowledge up to date to maintain competence and performance NB: **Until Practitioner is assessed as competent two signatures**

Appendix 5 – Confirmation of the Fact of Death

CARDIFF AND VALE UHB
CONFIRMATION OF THE FACT OF AN EXPECTED DEATH

Date and Time Reported By Family/Care Home :	Date and Time Confirmed by Practitioner :
Patient's Name :	DOB :
Patient's Address :	GP Name and Address :
Patients NHS Number :	History: There are no vital signs of life for a period in excess of minutes
1. Signs of spontaneous respiration (no respiratory effort observed / no breath sounds for 1 minute) 2. Signs of circulation (carotid or femoral pulses / heart sounds) 3. Cessation of cerebral function – (the pupils are fixed and unresponsive to light/no	Comments YES / NO YES / No YES / NO
Comments :	Life Extinct verified by (please print clearly)
Signature:	Does the patient have an ICD in situ YES / NO
Verification of Death: Date – Time -	Persons present at time of death:

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Information leaflets given to relatives: YES / NO	Relatives informed if not present at time of death: YES / NO
Has this case been referred to the Coroner: YES / NO	If YES – name of relative Have the Police been informed: YES / NO

CARDIFF AND VALE UHB
CONFIRMATION OF THE FACT OF AN EXPECTED DEATH
*****IN A VENTILATED PATIENT*****

Date and Time Reported By Family/Care Home / Ward :	Date and Time Confirmed by Practitioner :
Patient's Name :	DOB :
Patient's Address :	GP Name and Address :
Patients NHS Number :	History: In the ventilated patient you must: 1. Confirm the patients identity 2. Confirm the decision to withdraw treatment
After asystole confirm: 1. Signs of circulation (carotid or femoral pulses / heart sounds) 2. Cessation of cerebral function – (the pupils are fixed and unresponsive to light/no reaction to painful stimuli)	Comments
The ventilator can now be disconnected	YES / NO YES / NO
Ascultate for:	YES / NO
Comments :	Life Extinct verified by (please print clearly
Signature:	Does the patient have an ICD in situ YES / NO
Verification of Death: Date – Time -	Persons present at time of death:

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Information leaflets given to relatives: YES / NO	Relatives informed if not present at time of death: YES / NO
Has this case been referred to the Coroner: YES / NO	If YES = name of relative Have the Police been informed: YES / NO



Referral of Deaths to HM Coroner
SOUTH WALES CENTRAL

GUIDANCE

By virtue of s.1 Coroners and Justice Act 2009, a Coroner has a duty to investigate a death where there is *reason to suspect* that the death is:-

- Violent
- Unnatural
- Of unknown cause
- Has occurred whilst in custody or state detention

There are no statutory guidelines which set out which deaths have to be reported to HM Coroner. The categories of cases set out below are therefore for guidance only and if there is any doubt whether a death should be referred, advice from the Coroners Office should be sought.

A death should be reported to HM Coroner when a doctor knows or has *reasonable cause to suspect* that:-

- the cause of death is unknown – (*probable* cause not certain cause). NB if the cause of death is known, on the balance of probabilities and is natural, there is no need to refer to the Coroner.
- the death has occurred as a result of trauma, violence or physical injury whether inflicted intentionally or otherwise – this includes deaths related to accidents.
- The death occurred as a result of poisoning, the use of a controlled drug, medicinal product or toxic chemical

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- The death is due to a hospital acquired infection in circumstances in which it could be said to be unnatural.
- The death is related to any treatment or procedure of a medical or similar nature
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic.
- The death occurred as a result of self-harm (including a failure of the deceased to preserve his own life) whether intentional or otherwise
- The death occurred as a result of an injury or disease received during or attributable to the course of the deceased persons work
- The death occurred a result of a notifiable accident, poisoning or disease
- The death occurred as a result of neglect or failure of care by another person or self-neglect
- The death has occurred or illness arisen during or shortly after the deceased has been in contact with the police
- The death is related to abortion (miscarriage or termination)

- The death occurred whilst in custody or state detention – whatever the cause of death (Mental Health Act Section, Imprisonment etc.) NB – there is no longer a legal requirement to automatically hold an inquest where there is a Deprivation of Liberty Safeguarding Order (DoLS) in place if the cause of death is natural and there is no other reason to refer to the Coroner.
- the identity of the deceased is not known
- where the Registration Regulations cannot be complied with i.e. The certifying Dr must have *attended patient in last illness and either such attendance was within last 14 days OR the Dr has viewed the body after death*
- the death was otherwise unnatural i.e. Not due to natural causes.

NOTES

1. There is no longer a requirement to refer a death *just because* the deceased had in the past, worked as a miner if the cause of death is clearly not related to that occupation.
2. There is no longer a need to refer a death where death has occurred within 24 hours of admission to hospital provided the cause of death is known and it is natural.
3. Falls. Unless there is reason to suspect that a fall has caused or contributed to death, there is no need to refer the death to the Coroner. If there is any doubt, advice should be sought.
4. Deaths following surgery. Unless there is reason to suspect that the surgery or procedure has caused or contributed to the death, there is no need to refer the death to the Coroner. If there is any doubt, advice should be sought.
5. Deaths related to alcohol need not be referred if the cause of death is due to chronic alcohol related disease. It must be referred if it is due to acute alcohol

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poisoning. Remember also that if alcohol has played a role in an accidental death – the death should be referred.

6. Reporting doctors are reminded of their duty of candour when reporting deaths to HM Coroner – Good Medical Practice 2013 (General Medical Council) : <http://www.gmc-uk.org/guidance>
7. Reporting doctors are also reminded of their legal obligation under s.22 of the Births Deaths and registration Act 1953 to provide a cause of death – to the best of his / her knowledge and belief.

A.R. BARKLEY HM Coroner
October
2017

Appendix 7 – Nurse Midwifery Council

The NMC Code (2015) – contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary.

Registrants have a responsibility to deliver safe and effective care based on current evidence, best practice, and where applicable, validated research.

A nurse cannot legally *certify death* - this is one of the few activities required by law to be carried out by a registered medical practitioner. In the event of death, a registered nurse may *confirm or confirm life extinct*, providing there is an explicit local protocol in place to allow such an action, which includes guidance on when other authorities, e.g. the police or HM Coroner, should be informed prior to removal of the deceased.

Registered nurses undertaking this responsibility should only do so providing they have received appropriate education and training and have been assessed as competent. They must also be aware of their accountability when performing this role.

Appendix 8 – Further Information

NMC Code (2015) Professional Standards of Practice and behaviour for Nurses and Midwives - www.nmc.org.uk/standards/code/read-the-code-online/

NMC advice sheet on Accountability

Department of Health (England) www.dh.gov.uk

The Scottish Executive www.scotland.gov.uk

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The Welsh Assembly www.wales.gov.uk

Department of Health and Social Services and Patient Safety of Northern Ireland

www.dhsspsni.gov.uk

Health and Personal Social Services in Northern Ireland www.n-i.nhs.uk

Community and District Nurses Association www.cdna-online.org.uk

Community Practitioners and Health Visitors Association www.amicus-cphva.org

Royal College of Nursing www.rcn.org.uk

Royal College of Midwives www.rcm.org.uk

UNISON www.unison.org.uk

Appendix 9 – Equity Health Impact Assessment

Impact on population health	No impact
Quality and / or Safety implications	No impact
Patient / Carer Experience implications	No impact
Additional workforce requirements	No impact
Education and Training requirements	No impact
Financial implications	No impact
Legal implications	No impact
Equality impact	No impact
Communication / Consultation / engagement requirements	No impact
Affect one group less or more favourably than another on the basis of: Race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, or disability	No Impact

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References:

British Medical Association (1999) - Guidance for GPs in England and Wales: Confirmation and Certification of Death - BMA.

Joint Royal Colleges Ambulance Liaison Committee (2003) - Recognition of life Extinct (ROLE) by Ambulance Staff - The Joint Royal Colleges Ambulance Liaison Committee.

NMC Code (2015) Professional Standards of Practice and behaviour for Nurses and Midwives - www.nmc.org.uk/standards/code/read-the-code-online/

Nursing & Midwifery Council (2012) Confirmation of Death. A-Z advice sheet. NMC, London.

Referral of a Death to HM Coroner (2017) - South Wales Central Guidance – A R Barclay HM Coroner Oct 2017.

Welsh Government: A clinical Policy for Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) for Adults in Wales, 2017

Other supporting documents are:

List all documents the reader needs to be aware of alongside / in support of this document

-

Scope

This policy applies to all of our staff in all locations including those with honorary contracts including the primary and community settings ‘in and out of hours’

Equality and Health Impact Assessment

An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in...../or incorporated within this policy/supporting procedure.
Note: Policies will not be considered for approval without an EHIA

Policy Approved by	Board/Committee/Sub Committee
Group with authority to	For example: Health System Management Board

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approve procedures written to explain how this policy will be implemented	
Accountable Executive or Clinical Board Director Director [insert title of post holder]

Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate.](#)

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	18/12/2018	08/05/2019	New document
2			

Equality & Health Impact Assessment for

{insert title of strategy/ policy/ plan/ procedure/ service}

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
 - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
 - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required¹
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Confirmation of an Expected Death in Adults – (18yrs and over)
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Primary Community and Intermediate Clinical Board Kay Jaynes - Director of Nursing – 02921834521 Helen Earland – Senior Nurse Primary Care / Clinical Nurse Lead OOH – 02920 335287
3.	Objectives of strategy/ policy/ plan/	The aim of the document 'Confirmation of an Expected Death' is to

¹http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

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	procedure/ service	<p>ensure that:-</p> <ul style="list-style-type: none"> • Quality of care provision to the deceased and bereaved by promoting a consistent approach to the confirmation of death procedures across Cardiff and Vale UHB. • Staff who undertake the procedure are trained and competent. <p>The expected outcomes of this policy are as follows -</p> <ul style="list-style-type: none"> • For the death of the patient to be dealt with in a timely, sensitive and caring manner; • The death is dealt with in accordance with the law; • The Registered Nurse / Midwife / Paramedic skills and competencies are used appropriately; The distress of relatives can be reduced by having parenteral medication devices disconnected promptly and appropriately following the death of a patient, once confirmation of death has been established; • All religious and cultural needs of the patient will be clearly identified and recorded in the patients nursing documentation prior to death.
4.	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research 	<ul style="list-style-type: none"> • Cardiff & Vale University Local Health Board (LHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales' capital city: Cardiff. 72.1 and 27.9 percent of the LHB area population live within Cardiff and the more rural Vale of Glamorgan respectively • The UHB's usual arrangement with regard to consultation was followed (ie. 28 days on the intranet). No comments were received. • A part of good practice, other policies from different

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<ul style="list-style-type: none"> • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages <p>Population pyramids are available from Public Health Wales Observatory² and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need³.</p>	<p>organisations were considered.</p> <ul style="list-style-type: none"> • Internal Stakeholders were engaged in the EHIA and/or policy development (Directors of Nursing from Each Clinical Board and other appropriate nursing leads from across the organisation). • NMC Code (2015) Professional Standards of Practice and behavior for Nurses and Midwives - www.nmc.org.uk/standards/code/read-the-code-online/ • NMC advice sheet on Accountability • Department of Health (England) www.dh.gov.uk • The Scottish Executive www.scotland.gov.uk The Welsh Assembly www.wales.gov.uk • Department of Health and Social Services and Patient Safety of Northern Ireland www.dhsspsni.gov.uk • Health and Personal Social Services in Northern Ireland www.n-i.nhs.uk • Community and District Nurses Association www.cdna-online.org.uk • Community Practitioners and Health Visitors Association www.amicus-cphva.org • Referral of a Death to HM Coroner (2017) - <u>South Wales Central Guidance</u> – A R Barclay HM Coroner Oct 2017 • Royal College of Nursing www.rcn.org.uk • Royal College of Midwives www.rcm.org.uk • UNISON www.unison.org.uk
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² <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

³ <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

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5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy applies to all UHB staff who carry out the process of 'Confirmation of an Expected Death' within Cardiff and Vale UHB
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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: <ul style="list-style-type: none"> • under 18; • between 18 and 65; and • over 65 	This policy is related to confirmation of an expected death in adults only – therefore would not be applicable for anyone under the age of 18yrs	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disability would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
<p>6.3 People of different genders: Consider men, women, people undergoing gender reassignment</p> <p>NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender</p>	<p>Gender or gender reassignment would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner</p>	<p>N/A</p>	<p>N/A</p>
<p>6.4 People who are married or who have a civil partner.</p>	<p>Marital status would not be a factor to consider within this 'Confirmation of an Expected</p>	<p>N/A</p>	<p>N/A</p>

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Death Policy' – as not within the criteria for referral to HM Coroner		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	The death of a woman expecting a baby, on a break from work or breast feeding – would not sit under the 'Confirmation of an Expected Death' Policy – but be within the criteria to refer on to HM Coroner. This would be termed as an Unexpected / Unexplained death.	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The death of a person of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers would not be a factor to consider within this 'Confirmation of an	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	Expected Death Policy' – as not within the criteria for referral to HM Coroner. Health care professionals do need to be aware of cultural beliefs in relation to the after care of a person confirmed dead and their family / carers		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	People with a religion or belief or with no religion or belief would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner. Health care professionals do need to be aware of religious beliefs in relation to the after care / burial of a person confirmed dead	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
<p>6.8 People who are attracted to other people of:</p> <ul style="list-style-type: none"> • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual) 	<p>People who are attracted to other people of the same sex, different sex or both sexes would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.</p>	<p>N/A</p>	<p>N/A</p>
<p>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	<p>People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.</p>	<p>N/A</p>	<p>N/A</p>

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	However bilingual patient information leaflets are available for the deceased relatives. This is in line with our current Welsh Language Scheme and the future Welsh Language Standards.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	People on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Living conditions of the dead individual would not be a factor to consider within this 'Confirmation of an Expected Death Policy' – as not within the criteria for referral to HM Coroner.	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Not applicable to this policy	N/A	N/A

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities</p> <p>Well-being Goal - A more equal Wales</p>	Confirmation of death is the responsibility of appropriately trained health care professionals working in and out of the hospital setting, across the whole of Cardiff and Vale – immaterial of demographics of the deceased	N/A	N/A
<p>7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention).</p>	N/A for this policy	N/A	N/A

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Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Confirmation of death is the responsibility of appropriately trained health care professionals working in and out of the hospital setting, across the whole of Cardiff and Vale – immaterial of financial and employment status of the deceased	N/A	N/A
7.4 People in terms of their use of the physical	For this policy, there will be no impact.	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces</p> <p>Well-being Goal – A resilient Wales</p>			
<p>7.5 People in terms of social and community influences on their health: Consider the impact on</p>	For this policy, there will be no impact	N/A	N/A

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos</p> <p>Well-being Goal – A Wales of cohesive communities</p>			
<p>7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate</p>	<p>Guidance on the referral of Deaths to HM Coroner – South Wales Central - 2017</p> <p>British Medical Association (1999) - <u>Guidance for GPs in England and Wales: Confirmation and Certification of Death</u> - BMA. Nursing & Midwifery Council</p>	N/A	N/A

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Well-being Goal – A globally responsible Wales	(2012) Confirmation of Death. A-Z advice sheet. NMC, London. Joint Royal Colleges Ambulance Liaison Committee (2003) - <u>Recognition of life Extinct (ROLE) by Ambulance Staff</u> - The Joint Royal Colleges Ambulance Liaison Committee.		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

<p>8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service</p>	<p>On writing the first UHB wide policy for the 'Confirmation of Expected Death', this will provide a structured document, underpinned by a stringent governance framework for all health care professionals undertaking this role whether in the hospital, community or primary care sector. It promotes quality of care provision to the deceased and bereaved by promoting a consistent approach. Input in to this document has been received from all relevant areas of care across the UHB. Overall, there appears to be minimal impact on the protected characteristics and health inequalities as a result of this policy.</p>
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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Overall, there appears to be very minimal impact on the protected characteristics and health inequalities as a result of this policy – and a UHB wide document will underpin a stringent governance framework for all Health Board employee’s confirming death	Kay Jeynes DoN	1 month	Action in accordance with UHB Employment Policies and Procedures.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very minimal impact identified, it is unnecessary to undertake a more Detailed assessment.	Kay Jeynes DoN	N/A	

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> • Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review 	<p>The policy in its current format has been adjusted / amended in accordance With consultation agreements across the UHB.</p> <p>Policy to be added to the NMB – Directors of Nursing Cardiff and Vale – agenda for approval</p> <p>Once approval received the policy will be reviewed on a three yearly basis as per UHB policy. When this policy is reviewed, this EHIA will form part of the consultation exercise. This EHIA will also be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that earlier review is required.</p>	<p>Kay Jeynes DoN</p> <p>Kay Jeynes DoN</p> <p>Kay Jeynes DoN</p>	<p>Completed</p> <p>2 months</p> <p>3 years</p>	

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Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)⁴

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

⁴ <http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015>

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)⁵
- Equality Act 2010⁶
- Well-being of Future Generations (Wales) Act 2015⁷
- Social Services and Well-being (Wales) Act 2015⁸
- Health Impact Assessment (non statutory but good practice)⁹
- The Human Rights Act 1998¹⁰
- United Nations Convention on the Rights of the Child 1989¹¹
- United Nations Convention on Rights of Persons with Disabilities 2009¹²
- United Nations Principles for Older Persons 1991¹³
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance¹⁴
- Welsh Government Health & Care Standards 2015¹⁵
- Welsh Language (Wales) Measure 2011¹⁶

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (i.e. their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

⁵ <http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en>

⁶ <https://www.gov.uk/guidance/equality-act-2010-guidance>

⁷ <http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en>

⁸ <http://gov.wales/topics/health/socialcare/act/?lang=en>

⁹ <http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782>

¹⁰ <https://www.equalityhumanrights.com/en/human-rights/human-rights-act>

¹¹ <http://www.unicef.org/UNICEFs-Work/UN-Convention>

¹² <http://www.un.org/disabilities/convention/conventionfull.shtml>

¹³ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>

¹⁴ <http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf>

¹⁵ <http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en>

¹⁶ <http://www.legislation.gov.uk/mwa/2011/1/contents/enacted>

They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates¹⁷
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide¹⁸

¹⁷ <http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf> (accessed 4 January 2016)

¹⁸ <http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782> (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998¹⁹

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person

¹⁹ <https://www.equalityhumanrights.com/en/human-rights/human-rights-act>

13. solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
14. Protocol 1, Article 1 Right to peaceful enjoyment of your property
15. Protocol 1, Article 2 Right to education
16. Protocol 1, Article 3 Right to participate in free elections
17. Protocol 13, Article 1 Abolition of the death penalty

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seeks views and opinions.

