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SevernSide

Integrated Urgent Care

Death Administration SOP

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Introduction

This Death Administration SOP has amalgamated several existing processes on Radar and Clinical Toolkit:

- Supported verification of life extinct in an expected death Severnside Out of Hours (OOH)
- Requests for death certificates in OOH
- Death Verification and Management of 'Expected', 'Unexpected but not a surprise' and 'Unexpected' Deaths in OOH
- Procedure for the management of resuscitated deceased persons during out of hours following NHS 111 telephone assessment or 999 ambulance call in Bristol, North Somerset and South Gloucestershire (BNSSG)

During the COVID pandemic, the death verification process and guidance supported remote verification. **Remote verification is no longer supported**. The former pandemic protocols for remote verification have ceased.

Severnside clinicians will continue to discuss community deaths with paramedics and other healthcare professionals to help with decision-making around expected vs unexpected deaths, but responsibility for verification of death lies with a trained and competent person, who is physically present with the deceased.

Aim of this SOP

The main aim of this SOP is to ensure that Severnside provides the best possible care for the deceased and for the family or carers, whilst also supporting our clinicians. This SOP also ensures that due process is followed regarding all our system partners, the Home Office (delegated to the Police), Coroners, SWAST, and that it follows best practice.

This guidance is based on

- Academy of Medical Royal College (2025) Code of Practice for the diagnosis and confirmation of Death
- South Western Ambulance Service (SWAS, 2024) Management of Adult Non-suspicious Sudden Death (NSSD) SOP.
- Home Office (2024) Dealing with Sudden Unexpected Death
- Ministry of Justice (2024) Guidance for registered medical practitioners on the Notification of Death regulations

Definitions used in this Guidance

Verification is the examination of the deceased person to confirm that they are dead, and the documentation of this. It can be completed by any qualified and competent person using the AOMRC guidance.

Certification is the process of completing the Medical Certificate of Cause of Death (MCCD). In the community this is usually completed by the patient's own GP.

Expected death is the result of an acute or gradual deterioration in a patient's health, usually due to an advanced, progressive, or incurable disease. The death is anticipated, expected, and predicted. There may, in these circumstances, be an Advance Care Plan and a Recommended

Summary Plan for Emergency Care and Treatment (ReSPECT) form agreed with the patient. Some expected deaths may require reporting to the coroner, such as disease attributable to a person's employment, but coronial notification can be done in the next working day by the patient's own GP Practice. This would be the majority of cases within IUC.

Unexpected death is not anticipated or related to an illness that has been identified as terminal. In these circumstances a patient's GP is often unable to issue a MCCD and the death may need to be referred to HM Coroner.

Historically, the Police have been required to attend all unexpected deaths, even when there are no suspicious circumstances. This is no longer the case.

- All unexpected deaths should be discussed with the Police using the Police Control Room on 0300 369 0356 (or 101 if no answer). They may need Police involvement, especially if truly unexpected.
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Suspicious death would involve the following criteria and may require police attendance:

- Where criminality may be a factor.
- The death appears to be because of a violent accident.
- Suicide is suspected.
- The death was due to drug abuse or misuse.
- The death occurred away from the deceased's home address or care home.
- The death has occurred in prison, custody, or Ministry of Defence (MOD) premises.
- The deceased cannot be identified.
- No responsible relative or carer is present at the scene.
- The Police feel it is necessary to attend given the circumstances reported to them.
  -
  - All suspicious circumstances related to deaths must be discussed with the Police using the Police Control Room on 0300 369 0356 (or 101 if no answer) and will need Police involvement.

A **non-suspicious death** is a death where nobody else was involved and the criteria above do not apply.

Medical Examiners are senior medical doctors providing independent scrutiny of the causes of death. They are also versed in the legal and clinical elements of the death certification process and liaise with the bereaved family. They seek to answer:

- What caused the death of the deceased?
- Does the coroner need to notified of the death?
- Was the care before death appropriate?

Coroners are usually lawyers and work within the framework of parliamentary law and have a legal duty to investigate certain deaths, including where a death was unnatural or violent of where the cause of death remains unknown. Referrals are mainly made by doctors, medical examiners and the Police. When a coroner receives a referral, they will decide whether there is a duty to investigate and may undertake preliminary enquiries before making that decision. The coroner will usually consider the information on the same or the next working day but sometimes it can take longer if, for example, further information is required or a doctor has to be located who can issue the MCCD. The process thereafter will depend on the circumstances.

Our roles and responsibilities

- Provide compassionate care and support to deceased patients, bereaved relatives and caregivers
- Assist community partners with decision-making around the nature and management of death
- Visit and verify death where there is no trained and competent person on-scene to do so in a timely manner
- Escalate and refer to the police or coroner for unexpected deaths and/ or suspicious deaths

Principles

BrisDoc clinicians should consider whether a death is expected or unexpected. In lay terms this means the death is 'explainable'.

For most patients who have died and BrisDoc involvement has been sought, the death will be expected.

Clinicians should also consider whether there are any concerns regarding suspicious circumstances surrounding the death. In very rare circumstances it may be possible to have an expected death *and* suspicious circumstances.

Verification within OOH can be undertaken for all expected deaths with no suspicious circumstances, and unexpected deaths with no suspicious circumstances.

All cases should be discussed with the Police Control Room on 0300 369 0356 in the unlikely event of an unexpected death with or without suspicious circumstances, or any suspicion surrounding an expected death.

If a GP has attended the deceased in the patient's **lifetime**, then the GP can undertake the death certification process (MCCD). It is no longer guidance that a patient who has not been seen by the GP for over the last 28 days of life will automatically need discussion with the coroner.

Coroner process

A person's death should always be notified to the coroner where there is reasonable cause to suspect that the death was due to any of the following:

- poisoning including by an otherwise benign substance
- exposure to, or contact with, a toxic substance
- use of a medicinal product
- the use of a controlled drug or psychoactive substance
- violence, trauma or injury
- self-harm
- neglect including self-neglect
- the person undergoing any treatment or procedure of a medical or similar nature
- an injury or disease attributable to any employment held by the person during the person's lifetime
- suspicion that the person's death was unnatural but does not fall within any of the above circumstances.
- the cause of death is unknown

- the registered medical practitioner suspects that the person died while in custody or otherwise in state detention
- there is no attending practitioner, or an attending practitioner is not available within a reasonable time to sign a MCCD in relation to the deceased person
- the identity of the deceased person is unknown.
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- All coronial deaths (usually unexpected) should be discussed with the Police using the Police Control Room on 0300 369 0356 (or 101 if no answer) and may need Police involvement. If a referral to the coroner is indicated, the IUC clinician should make a coroner referral following the process outlined below.

The coroner's senior officer has advised that for deaths with no suspicious circumstances but a degree of uncertainty whether the death is unexpected, the key principle is whether it is explainable and there are no suspicious circumstances. It may still require coronial input – see Coroner process. However, the death can be treated as unexpected and be verified in OOH. It may be that the patient's GP Practice can follow up coronial involvement and / or Medical Examiner involvement the next working day.

Verification of death

Who can Verify?

Verification is the diagnosis and confirmation of death and **must be done by a trained and competent person with the approval to verify death and who is physically present with the patient**. The law does not specify who can verify a death, unlike certification which is legally required to be done by a doctor. Verification is commonly performed by a paramedic, community nurse, GP, Advanced Clinical practitioner (ACP) or other Health Care Practitioner (HCP).

Many community HCPs, such as nurses working in nursing homes, will be able to verify deaths but may call Severnside for support with verification. This may be around the decision-making regarding expected or unexpected, or guidance around the coronial process. This may involve looking up EMIS notes and talking through situations. Providing the person on scene is trained and approved to verify death, the responsibility for the verification remains with the community HCP as the on-scene person.

If the community HCP cannot verify and they are not competent or trained in verification, then a home visit from a Severnside clinician will be required.

The verification Process

Role of the Severnside Call Handler

To follow usual process and enter case on the queue.

Role of the Severnside clinician

To speak with the clinician who is present with the patient.

- Confirm if the clinician present with patient is trained and competent in death verification
- If the community clinician is verifying the death, request that their documentation clearly states the name of the verifying clinician for all onward notification purposes.

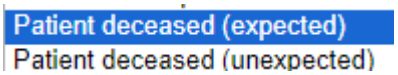
- discuss the circumstances leading to death, using EMIS to confirm background information
- confirm that the death was expected or unexpected (or suspicious) and whether coronial input or police input is required

It will be the clinician with the patient that will be conducting the verification procedure. The Severnside clinician's role is to give any additional clinical information required to assist with this procedure. The Severnside clinician must be satisfied that there are no suspicious circumstances. If there are any suspicious circumstances, then the verification should **not** be assisted by Severnside.

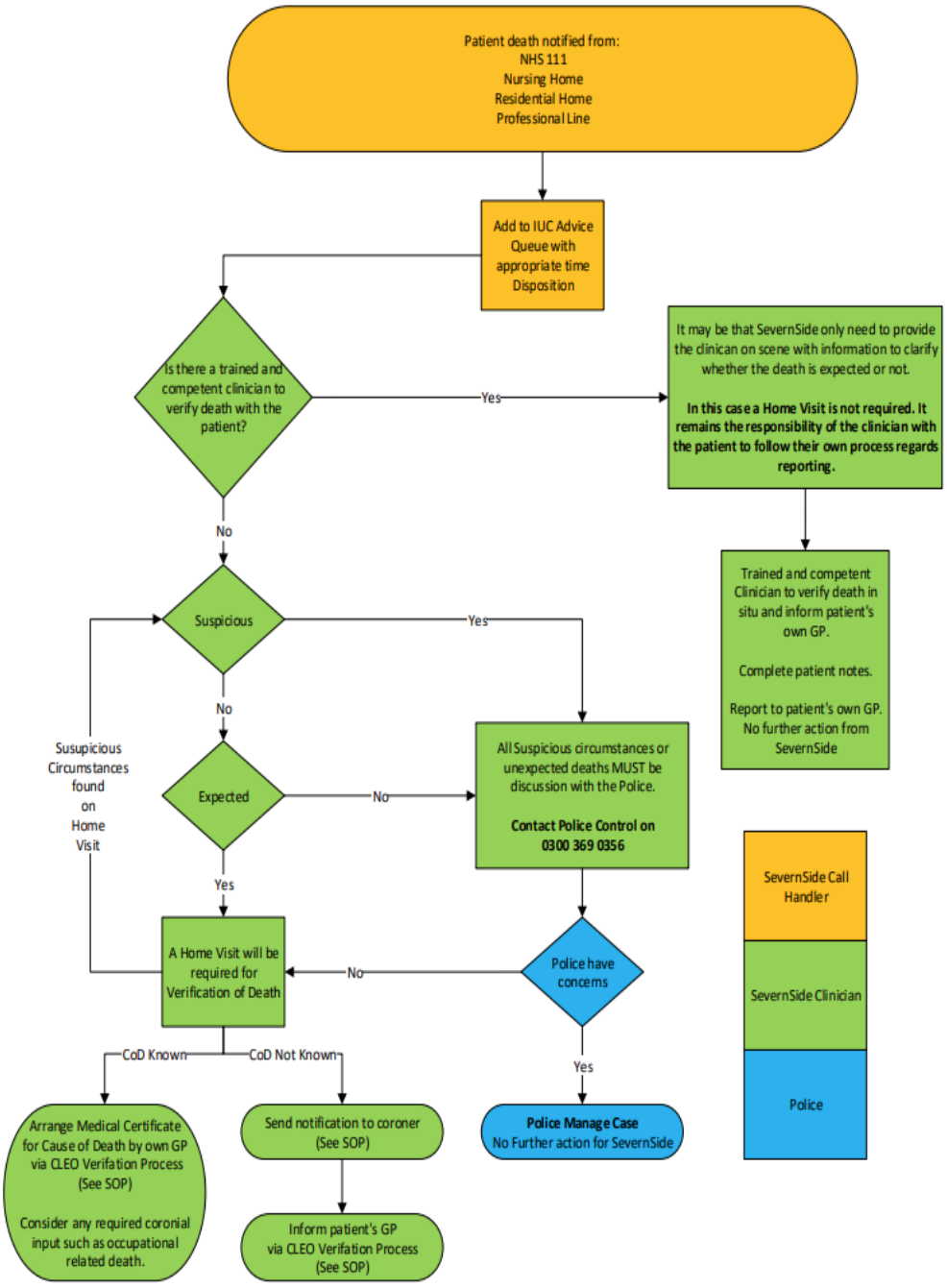
All suspicious circumstances regarding deaths must be discussed with the Police using the Police Control Room on 0300 369 0356 (or 101 if no answer) and will need Police involvement.

The SevernSide clinician must document and follow the process below:

- Caller name and name of person who verified the death
- Professional status and confirmation they are trained and approved to verify death
- How the death has been verified - i.e. by somatic or circulatory criteria (see AOMRC Guidance)
- Time of the verification of death
- Expected or unexpected and no suspicious circumstances
- Close the case using the one of the 'death' Read clinical code and the informational outcome code "Patient Deceased (Expected) or Patient Deceased (Unexpected). Document in notes if death was unexpected but clinical rationale for subsequent actions. Either option, expected or unexpected will result in the patient's own GP Surgery being contacted the next working day. This will alert the Practice of the patient death and the Practice can make arrangements for the Medical Certificate of Cause of Death (MCCD) (death certificate), +/- cremation form and any coronial process.



Death Verification Process in OOH



Death of patient whilst on OOH caseload

Death of patient whilst on queue awaiting a call back

There may be a death of patient during a remote clinical telephone triage or while waiting for a clinical call back or follow up phone call.

Consider supporting SevernSide colleagues involved in the case.

It may be appropriate to consider arranging a home visit to verify the death if there is no one present, trained and competent within the community to perform verification.

A learning event must be submitted for all instances where a patient has died whilst on the Severnside case load.

Death of patient whilst on scene (ie Face-to-Face assessment)

In the rare event when a home visit has been arranged for a patient and the patient dies during the home visit then please follow the guidance for within this SOP. This guidance is for unexpected deaths. Expected deaths can be managed using the process outlined in Verification of Death.

- All unexpected deaths should be discussed with the Police using the Police Control Room on 0300 369 0356 (or 101 if no answer) and may need Police involvement.

A verification of death may be performed where possible but minimise contaminating the scene.

A learning event must be submitted. This is required due to CQC reporting requirements.

Suspicious circumstances

If there is clear evidence of third-party involvement (e.g. homicide) or suspicious or unusual circumstances surrounding the case, then call the Police immediately on 999. Ensure the visiting Clinician and Driver are safe. The Clinician and Driver will need to stay at scene and hand over directly to the attending Police.

When can the Severnside Clinician depart the scene?

The OOH Clinician may leave the scene in the instance of an unexpected death or expected death with no third-party involvement or suspicious circumstances if there is a Responsible Adult available. A Responsible Adult is defined as next of kin, close relative or a friend who has known the patient for an extensive period and is able to identify the patient.

The Responsible Adult will then await with the patient for funeral directors or, more rarely, Police arrival. If there is no Responsible Adult, it is the responsibility of the OOH Clinician to wait with the deceased patient.

Actions for SevernSide Clinician

Ensure the following information is documented about the Responsible Adult:

- Who the patient has been left with (including contact details)
- What relationship they had with the patient
- How long they have known the patient

A Learning Event must be submitted for all unexpected deaths of patient during a home visit.

Family/ Carer and Professionals' Wellbeing

Deaths can be distressing for family, friends and professionals attending the scene.

Ensure that family and friends are supported and signposted to their own GP surgery or the following bereavement organisations:

- Bereavement support (bristol.gov.uk) - A clear step by step guide for families in these situations is available as follows:
- What to do when someone dies: step by step - GOV.UK

All co-owners can access the Employee Assistance Programme and Well Being Hub. Co-owners can also access their line managers.

The Staff Wellbeing Hub – Radar (radar-brisdoc.co.uk)

Coroner referral Process

If the death needs to be reported to the coroner, this should be undertaken by the IUC Clinician.

Referrals to the coroner can be made through the Avon Coroner via the 'report a death' tab that takes you to electronic portal referral. A generic 'reference' is needed to access the portal; this can be found on Remedy and is currently BS48 1UL. This must be entered exactly as it appears.

If the referring clinician is not a doctor, please state this is in the notes of the referral. Although the referral form states 'doctor', a referral to the coroner may be completed by Nurses and AHPs.

Requests for death certificates in OOH

This Guidance is taken from Medical Examiner Service (MES) for Bristol, North Somerset and South Gloucestershire Policy and Standard Operating Procedure for Out of Hours Service Version 1.0

Medical Examiner out of hours telephone number: 0117 414 1531

There are no GP surgeries in BNSSG that issue Medical Certificate of Cause of Death (MCCD) out of hours. SevernSide OOH stocks MCCD books, but it is unlikely that a BrisDoc doctor will have attended the patient in their lifetime. In most cases the MCCD will be completed by the patient's usual GP in normal working hours.

There may be rare occasions when religious or cultural requirements warrant contacting the OOH Medical Examiner to discuss consideration of a Medical Examiner Certification process. These may include patients for whom the burial or repatriation is due to take place on a Sat / Sun or Bank Holiday at short notice, when the usual GP is unavailable.

Hours of operation and specifications of service

The out of hours service is operational **between the hours of 07:30-18:00 on Saturdays, Sundays, and Bank Holidays** throughout the year.

These hours are subject to change based on demand and regular review.

The service is primarily a remote one, with the option for Medical Examiners (MEs) to attend a hospital or other healthcare provider site where notes are kept for the purposes of facilitating scrutiny at the discretion of the individual Medical Examiner.

A Coroner's Officer and the Register Offices are on call 24 hours. The Register Office, however, will not facilitate a registration overnight.

Pre-Mortem Record of Scrutiny

For patients who are receiving end of life (EoL) care that are anticipated to die over a weekend or Bank Holiday from expected causes, a degree of pre-mortem scrutiny may be undertaken.

The law stipulates that a Medical Examiner may only access the medical records of a deceased person; therefore, this pre-scrutiny may only take the form of a conversation with an Attending Practitioner unless the patient gives consent in life for their records to be accessed. It is for the clinical team to approach the patient regarding access to their notes pre-mortem.

Clinical teams at all inpatient healthcare provider sites (acute hospitals, adult and children's hospices, Sirona rehabilitation units) are aware that they may contact the relevant ME Office on the last working day before a weekend or Bank Holiday to discuss the anticipated cause of death for a patient that fits the criteria for out of hours scrutiny (with or without notes scrutiny). They may then record the agreed cause of death in the patient notes.

If a cause of death has been discussed in advance, the ME or MEO in the relevant office should, on the last working day before the weekend or Bank Holiday, notify the on-call ME via the shared email inbox. The email should include:

1. Patient details, including three patient identifiers
2. The location of the patient
3. A brief description of circumstances/scrutiny undertaken (i.e. anticipated cause of death, whether pre-mortem notes scrutiny was undertaken with patient's consent)
4. The location of existing scrutiny documents, if any exist (i.e. Evolve, EMIS).

If the ME receives notification that the patient has died, the on-call ME should access any existing scrutiny documents on EMIS or Evolve to familiarise themselves with the content before proceeding with the usual out of hours process as outlined below.

The Attending Practitioner (AP) will contact the on-call ME by phone and provide the following (by phone or by email to the ME shared inbox):

- Patient details, including three patient identifiers
- Contact details (telephone number) for themselves, the AP
- Contact details for the Next of Kin.

The ME will use the NBT laptop or other suitable device to scrutinise the medical records of the deceased on the EMIS system.

- Some degree of pre-scrutiny may have been undertaken pre-mortem (please see "Pre-mortem scrutiny").

The ME should then call the AP on the number provided to discuss the cause of death.

- If the death has been referred to the coroner and the coroner has declined to investigate, the AP should tell the Medical Examiner and send a copy of coroner's form CN1A to the ME shared email inbox.

If the ME and AP cannot agree on a cause of death, the ME should instruct the AP to refer the death directly to the coroner.

The ME will then call the Next of Kin on the contact details provided to discuss the cause of death and any concerns or queries.

- If the conversation with the Next of Kin brings to light the necessity for a coroner referral, the ME should call the AP to advise that they submit a coroner referral and close the case.
- For deaths registered at Bristol Register Office, the Medical Examiner should give the Next of Kin the Register Office out of hours phone number (07795445770) so that they may book an appointment.
- For deaths registered at Somerset Register Office, the Medical Examiner should ask the Next of Kin for their consent to pass their contact details to the Register Office, who will call the NoK to make an appointment.

The AP will scan the MCCD and send the copy to the shared Medical Examiner email inbox (nbn-tr.medicalexaminer@nhs.net).

The ME will countersign the MCCD.

- For deaths registered at Bristol Register Office, the ME must call the out of hours phone number on 07795445770 to advise that the MCCD has been sent.
- For deaths registered at Somerset Register Office, the ME must call a member of the Register Office team to advise that the MCCD has been sent.
- The ME must copy the AP of the relevant hospice into the email to advise them that the body may be released to the funeral director.

Funeral directors

For faith deaths, the family may have already engaged the services of a funeral director.

Funeral directors are likely to have a nominated contact within the deceased's family, and it may be helpful to contact the funeral director, if known, if you have difficulties contacting the Next of Kin or would like to seek advice on the most appropriate contact.

Contact details for the two largest local Muslim funeral directors can be found in "Contact details for relevant parties" below.

Aslam Funeral Services Ltd

Ruksana Aslam
Telephone: 07941360223
Email: aslamfunerals@gmail.com

Ummah Funerals

Shahid Akram
Telephone: 07831663730
Email: ummahfunerals@gmail.com

Change Register

Date	Version	Author	Change
November 2024 (Not published until Oct 2025)	1	Renuka Suriyaarachchi & Charlie Kenward	The following documents were all incorporated into one SOP: Supported Verification of Life Extinct in expected death v2.3 Requests for death certificates OOH (Dec 2022) Clinical Toolkit Death Verification and Management of 'expected', 'unexpected but not a surprise' and 'unexpected' deaths in OOH (Jan 2024) clinical Toolkit Guidance from Academy of Medical Royal Colleges (AOMRC, 2025) Procedure for the Management of resuscitated deceased persons during out of hours following NHS 111 telephone assessment or 999 ambulance calls in BNSSG (2016)
20th November 2025	1.1	Renuka Suriyaarachchi	Clarify majority of cases are expected Police control number checked and additional number included
7th May 2026	1.2	Renuka Suriyaarachchi	Clarify LE creation when patient on IUC caseload
5th November 2026	1.3	Renuka Suriyaarachchi/ Anne Whitehouse	Clarify coronial / ME process, clarify LE process at scene, added family guidance, Co-owner guidance