Guidance Note for the 'Verification of Death'

Information for Nurses and Paramedics

Context

At present, where a registered medical practitioner is unavailable immediately to sign a Medical Certificate of Cause of Death (MCCD) or to document in some other way that a person has died, there may be unnecessary delays in the movement of the deceased body to an appropriate location such as a mortuary, holding room or funeral service. This is because before a deceased body is moved, funeral directors require reassurance from a health professional that 'cessation of life' has occurred.

Significant delays in securing the attendance of a registered medical practitioner are more common where a death occurs in a remote, rural or isolated location or occurs during the night in a residential aged care facility. Such delays can cause distress to family members of the deceased. In addition, where a death occurs in a public place, funeral directors and ambulances are known to transport the deceased body to the nearest hospital emergency department to request that a registered medical practitioner verify the fact of death. These incidents impact on bed availability and core service delivery of hospital staff and ambulance services.

It has become apparent that the Department of Human Services needs to clarify that, in addition to registered medical practitioners, other health professionals (nurses and paramedics) are educated to and can verify the fact of death.

Purpose of the Guidance Note

The purpose of the guidance note is:

- to facilitate more timely verification of death and
- to alleviate any unnecessary delays in the movement of a deceased body from the place of death to a suitable location such as a mortuary, holding room or funeral service where a registered medical practitioner is unavailable immediately to sign the MCCD or to document in some other way that a person has died.

Who is allowed to 'Verify Death'?

Registered medical practitioners can 'verify death'. In addition, nurses and paramedics can 'verify death' as the law does not prevent them from undertaking this activity. Nurses and paramedics have always been able to 'verify death'. However, it has become apparent that the Department of Human Services needs to reinforce this as current clinical practice is to await the completion of a MCCD or other documentation (e.g. medical deposition) that 'verifies death' by a registered medical practitioner before a deceased body is moved from the place of death to a more appropriate location.

The Department of Human Services considers that the following people should have the expertise to competently undertake a clinical assessment of a body to establish that death has occurred ('verify death') as they have undertaken relevant training:

- A **Division 1 or Division 3 Registered Nurse** (within the meaning of the *Health Professions Registration Act 2005*)
- A **Paramedic**, (a person credentialed by Ambulance Victoria as either an Ambulance Paramedic or a MICA Paramedic)

Certification of Death

The legislative requirement for a registered medical practitioner to 'certify death' (a MCCD) under section 37 of *the Births Deaths and Marriages Registration Act 1996* remains unchanged. The MCCD can 'only' be completed by a registered medical practitioner.

To 'certify death' a registered medical practitioner is required to make a diagnosis of the cause of death which requires specialist knowledge.

Circumstances in which a nurse or paramedic should not 'verify death'

Protocols set by Health Services and Providers

This guidance note does not over-ride the protocols set by health services and providers around medical intervention **and resuscitation**. These should always be adhered to and given precedence before 'verifying a death'.

Non-Employment Context

Nurses and paramedics should only 'verify death' when acting within an employment context.

Process to 'verify death'

Minimum Guideline for the Clinical Assessment of a Body

The suite of clinical determinants below act as a minimum guideline for the clinical assessment necessary to establish that death has occurred ('verify death').

Professional clinical judgement is required to make this determination and unique circumstances may warrant additional checks over and above the minimum guideline provided below. An ECG may be taken in addition to the minimum assessments if warranted.

- No palpable carotid pulse and
- No heart sounds heard for 2 minutes and
- No breath sounds heard for 2 minutes and
- Fixed (non responsive to light) and dilated pupils and
- No response to centralised stimulus (e.g. trapezius muscle squeeze, supraorbital pressure, mandibular pressure or the common sternal rub) and
- No motor (withdrawal) response or facial grimace in response to painful stimulus (e.g. pinching inner aspect of the elbow)

Optional

- ECG strip shows no rhythm

Please refer to Appendix B which is a separate attachment of the 'minimum guideline for the clinical assessment of a body to verify death'.

Documentation

Nurses and paramedics must document their 'verification of death', their own name with professional title, the clinical determinants used (as contained within Appendix B), the date, the time and where the clinical assessment took place. This detail should be recorded within an appropriate record for the deceased (for example a health medical record, case notes or other file).

Notification
Nurses and paramedics must follow their employer's guideline or policy with regard to the notification of relatives and significant others (i.e. a funeral director and/or a registered medical practitioner).

Opt Out Option
'Verifying a death' is a voluntary act and is not mandated for either profession (nurse or paramedic). A nurse or paramedic can choose to defer to another appropriate health professional (nurse, paramedic, or registered medical practitioner).

'Reportable Deaths' and 'Reviewable Deaths'
Consideration must be given to whether the death is a 'reportable death' or a 'reviewable death', within the meaning of the *Coroners Act 1985*. If a person has reasonable grounds to believe that the death that appears to be reportable or reviewable has not already been reported, they must report the death as soon as possible to a coroner. The State Coroners Office can be contacted at any time by calling (03) 9684 4380. In the above circumstance, it is necessary to follow the directions given by the coroner. Please refer to 'Appendix A' which discusses 'reportable deaths' and 'reviewable deaths'. If a death is a 'reportable death' or a 'reviewable death' there are implications for the movement of the deceased body. Please refer to 'Movement of a Deceased Person' below.

Movement of a Deceased Person
If a 'reportable death' or a 'reviewable death' occurs and the body is in Victoria, the body is under the control of the coroner investigating the death until the coroner has issued a certificate permitting the body to be buried, cremated or otherwise disposed of. An investigation into the cause of a person's death could be jeopardised by moving the person's body before the scene of death has been properly examined and documented. For this reason, the deceased body should not be moved until directed to by the coroner.

However, provided that a death is not a 'reportable death' or a 'reviewable death', there is no legal restriction on the movement of the deceased body and it can be moved from the place of death to a more suitable location such as a mortuary or holding room, pending completion of a MCCD by a registered medical practitioner.

Further, there is no legal requirement for the funeral industry to obtain written verification that 'cessation of life' has occurred before moving the deceased body to a more appropriate location. However, it is to be expected that the funeral industry will require verbal reassurance that 'cessation of life' has occurred.

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Appendix A

Which deaths must be reported to the Coroner?

Under the Coroners Act*, "reportable deaths" and "reviewable deaths" must be reported to the Coroner.

Reportable deaths

A *reportable death* is a death:

- that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
- that occurs during an anaesthetic; or
- that occurs as a result of an anaesthetic and is not due to natural causes; or
- of a person who immediately before death was a 'person held in care'. This means:
    - a person under the control, care or custody of the Secretary to the Department of Human Services
    - a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police
    - a person in the custody of the police or a protective services officer appointed under the *Police Regulation Act 1958*
    - a patient in an assessment or treatment centre under the *Alcoholics and Drug-dependent Persons Act 1968*
    - a patient in an approved mental health service within the meaning of the *Mental Health Act 1986*
- of a person who was a patient within the meaning of the *Mental Health Act 1986* immediately before the person died but was not a person held in care;
- of a person under the control or care of the Secretary to the Department of Justice or a member of the police force; or
- a person who was subject to a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997;* or
- of a person whose identity is unknown;
- that occurs in Victoria where a death certificate has not been signed by a registered medical practitioner under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* and is not likely to be;
- that occurs at a place outside of Victoria where the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death.

Reviewable deaths

The death of a person under 18 years of age is a *reviewable death* if the death is the second or subsequent death of a child of a parent (including a step-parent, adoptive parent, foster parent, guardian or a person who has custody or daily care and control of a child).

* The *Coroners Act 2008* (the new Act) will replace the *Coroners Act 1985* (the current Act) on 1 November 2009. Please note that the definitions of the terms "reportable death" and "reviewable death" in the new Act are not identical to the definitions in the current Act.

Appendix B

Minimum guideline for the clinical assessment of a body to verify death

The suite of clinical determinants below act as a minimum guideline for the clinical assessment necessary to establish that death has occurred ('verify death'). Professional clinical judgement is required to make this determination and unique circumstances may warrant additional checks over and above the minimum guideline provided below.

- No palpable carotid pulse and
- No heart sounds heard for 2 minutes and
- No breath sounds heard for 2 minutes and
- Fixed (non responsive to light) and dilated pupils and
- No response to centralised stimulus (e.g. trapezius muscle squeeze, supraorbital pressure, mandibular pressure or the common sternal rub) and
- No motor (withdrawal) response or facial grimace in response to painful stimulus (e.g. pinching inner aspect of the elbow)

Optional

- ECG strip shows no rhythm