Humber Teaching
NHS Foundation Trust

Guidance for Staff Responsible for Care after Death (Last Offices)

Document Reference	G393
Version Number	3.04
Author/Lead **Job Title**	Debi Adams, Professional Lead for Palliative & End of Life Care
Date last reviewed, ratified and implemented (this version)	August 2022
Date of Next Review	August 2025
Consultation	Infection Prevention and Control Team Modern Matrons Chaplain Physical Health and Medical Devices Group Dr Sergio Raise, Associate Medical Director Janet Howe, Ward Manager
Date Ratified **Name of Ratifying Committee**	10 August 2022 Physical Health and Medical Devices Group

VALIDITY – Policies should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
2.00	14/9/09	
3.00	2/4/12	ERYPCT legacy document IC4 harmonised and reviewed.
3.01	14/5/12	Change to page 13, Islam guidelines.
3.02	April 2019	Title change from Care of the Deceased Patient Procedure to Guidance for Staff Responsible for Care after Death (Last Offices). Change of document reference number from Proc429 to G393. Changes to Appendix 1 and 2 in line with HSE 2018 guidance.
3.03	24/03/20	Amended to include guidance pertaining to COVID-19 section 5.3.1
3.04	10/08/22	Reviewed with no changes required. Approved at PHMD group (10/08/22).

Contents

1. INTRODUCTION

The nurse's role at the end of life extends beyond death to provide care for the deceased person and support to their family and carers. The physical care given by nurses following death in hospitals has traditionally been referred to as ‘last offices’, however the new terminology ‘care after death’ is intended to reflect the differing nursing tasks involved.

The physical preparation of the body itself will be called ‘personal care after death’. Care after death is a key responsibility for registered nurses in hospitals. In other settings (such as care and nursing homes, hospices and people’s own homes) those responsible may also include carers, social care staff, GPs and funeral directors.

The person who provides the care after death takes part in a significant process which has sometimes been surrounded in ritual. Although based on comparatively straightforward procedures, it requires sensitive and skilled communication, addressing the needs of family members/carers and respecting the integrity of the person who has died whilst recognising any infectious risks and or hazards are risk assessed and appropriate precautions are taken to reduce any cross infection risks to all staff who may come in to contact with the deceased person.

Care after death, while being the last act of nursing care, is the first stage of a pathway that involves a range of professional groups. This process leads ultimately to cremation or burial of the body. Professionals involved in this pathway include doctors, mortuary staff, hospital porters, ambulance staff, bereavement officers, police, social care staff, funeral directors, pathologists, coroners and faith leaders. Communication between these individuals and organisations is vital if the process is to run smoothly ensuring that the privacy and dignity of the deceased person is maintained and the health and safety of everyone who comes into contact with the body is protected.

2. SCOPE

This policy applies to all health care workers employed by Humber Teaching NHS Foundation Trust (including contractors, agency/locum staff, students and visiting/honorary consultant/clinicians) that undertake patient care, or who may come into contact with affected patients.

3. POLICY STATEMENT

Humber Teaching Foundation Trust is committed to supporting staff in providing safe and effective care to all patients. It acknowledges that when a patient dies whilst receiving care as an inpatient, then the deceased body must be treated with the utmost dignity and respect in a safe, efficient and compassionate manner.

This local guidance should also be read in conjunction with NHS National End of life Care programme in partnership with the National Palliative Care Nurse Consultants Group (2011) Guidance for staff responsible for care after death (last offices) and the Trust policies and other documents in section 11 References/Evidence/Glossary/Definitions.

4. DUTIES AND RESPONSIBILITIES

Chief Executive

The chief executive has overall responsibility for the effective implementation of this guideline.

Director of Infection Prevention and Control

Is responsible for ensuring that evidence based guidelines, policies and procedures in relation to the control of infection and prevention are developed and their implementation is monitored.

Executive and Senior Managers
Are required to be familiar with the existence of policy and guidelines and support its implementation throughout the organisation.

The Infection Prevention and Control Team
The infection prevention and control team will provide infection prevention and control advice when necessary and will seek advice from appropriate external agencies if required.

Unit Managers/Department Leads
The unit managers/department leads will ensure that this guideline is readily accessible and that all the staff they manage are familiar with the contents of this guideline and their responsibilities with regard to caring for the deceased patient in relation to minimising infection prevention and control risks.

All Clinical Staff
All health care workers are required to read and comply with this guideline at all times ensuring effective management of the deceased patient thus reducing infection prevention and control risks.

5. PROCEDURES

5.1. Infection Prevention and Control – Performing Care after Death (Last Offices)

The term 'care after death' is a broader term that reflects a multicultural society and also embraces all the differing nursing tasks involved, including the ongoing support of the family and carers. The term 'last offices' refers to the physical care given to a deceased patient which demonstrates continued respect for the patient as an individual The Royal Marsden Manual (2015).

'Expected deaths may be very different from those where a patient has died suddenly or unexpectedly. In certain cases the patient's death may need to be referred to the coroner or medical examiner for further investigation and possible post-mortem. If those caring for the deceased are unsure about this then the person in charge of the patient's care should be consulted before care after death has commenced. If the death is going to be referred to the coroner, advice must be sought before interfering with anything that might be relevant to establishing the cause of death' The Royal Marsden Manual (2015).

Standard precautions should be adhered to at all times when performing last offices, including the use of appropriate personal protective equipment (PPE), i.e. wearing disposable gloves and aprons. If there is a risk of splashing based on a risk assessment then protective eyewear should be worn. Elements of these precautions may not be a requirement for relatives/carers wishing to participate in the process, but this should be risk assessed on an individual basis. Some relatives/ carers may wish to assist with the personal care in acknowledgement of individual wishes, religious or cultural requirements. Prepare them sensitively for changes to the body after death and ensure they are aware of manual handling and potential infection control risks and the appropriate precautions.

The standard preparation of bodies usually involves the washing of the deceased hands and face, closing the eyes and mouth, tidying the hair and possibly shaving the face. In the case of cultural and religious rituals some significant others may want to prepare the body before burial.

5.2. Infection Prevention and Control – Prevention of Leakage of Body Fluids
In situations where the deceased person has a wound or wounds with potential exudate, all leaking wounds must be covered using an absorbent waterproof dressing.

Unless otherwise indicated i.e. if the death is to be referred to the coroner the following apply:

- Contain leakages from the oral cavity or tracheostomy sites by suctioning and positioning, suction and spigot nasogastric tubes.

- Cover exuding wounds or unhealed surgical incisions with a clean, absorbent dressing and secure with an occlusive dressing. Leave stitches and clips intact.
- Cover stomas with a clean bag. Clamp drains (remove the bottles), pad around wounds and seal with an occlusive dressing.
- Avoid waterproof, strongly adhesive tape as this can be difficult to remove at the funeral directors and can leave a permanent mark.
- Do not tie the penis.
- Spigot any urinary catheters.
- Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum.
- Cap intravenous lines and leave them in situ.
- If the body is leaking profusely then take time, pre transfer to the mortuary, to address the problem.
- If no referral to the coroner, tubes and lines may be removed in a community setting.

NHS National End of life Care programme in partnership with the National Palliative Care Nurse Consultants Group (2011).

Where the death is being referred to the coroner and there is any complaint about the care of the patient, or the circumstances surrounding the death give rise to suspicion that means the death requires forensic investigation;

- Leave all intravenous cannulae and lines in situ and intravenous infusions clamped but intact.
- Leave any catheter in situ with the bag and contents.
- Do not wash the body or begin mouth care in case it destroys evidence.
- Continue using standard precautions to protect people and the scene from contamination.
- Mortuary staff can provide guidance on this at the time of death.

Where the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances:

- Leave intravenous cannulae and lines in situ and spigot catheters.
- Infusions and medicines being administered prior to death via pumps can be taken down and disposed of according to local policy and recorded and documented in nursing and medical documentation.
- The contents of catheter bags can be discarded.

NHS National End of life Care programme in partnership with the National Palliative Care Nurse Consultants Group (2011)

If the patient's death has been reported to the coroner for a post mortem, then all devices are required to be left in situ. It is advised to keep a record of the devices which have been left in situ in the deceased person's notes. The practice of packing orifices should not be carried out as this can cause damage to the body.

If all the above actions have been taken and there is still a significant amount of body fluid leakage the use of a body (cadaver) bag is required once last offices have been completed and the body has been dressed in a shroud (or other appropriate clothing) and wrapped in a white sheet. The Royal Marsden Hospital Manual online (2015).

5.3. Infection Prevention and Control – Death of an Infectious Patient

The practitioner who verified the death is responsible for ascertaining whether the person had a known or suspected infection and whether this is notifiable Royal Marsden Hospital manual (2015).

There are a number of microorganisms which may pose an increased risk of transmission of infection to those handling the body both before and after death. In the majority of cases the stringent use of standard precautions and effective management of potential body fluids will provide adequate protection.

Please refer to Appendix 1 for further guidance on key infections and the precautions required including the use of body bags and the viewing of the body by relatives/carers.

As the restriction of access to the deceased person may cause great distress to the relatives/carers staff should first ensure that they have clarified the infectious status of the deceased.

The mortuary or funeral director should be informed of the infectious status of the patient by the Healthcare Professional who verifies the death or by the member of staff who is responsible for handing over the body of the patient to the mortuary or funeral director. All Trust staff should ensure that this notification has been made by completing the Hazard Notification Sheet – see Appendix 2 as stated in the Health and Safety Executive (HSE) (2018) guidance.

Staff should identify the hazards and how the activities, processes or microorganisms could cause harm to health, taking into account direct contact with the deceased as well as contact with objects such as contaminated sharps, soiled work surfaces, clothing that may have become contaminated with infectious microorganisms.

A risk assessment should include:

- the condition/presentation of the deceased;
- which microorganism(s) may be present;
- the routes of transmission (i.e. airborne, droplet or contact) and their infectious dose (i.e. minimum number of microorganisms required to cause infection);
- the information contained in the hazard notification sheet (see Appendix 2);
- the clinical history of the deceased;
- where available, the prevalence of particular infections in the community;
- the nature of any likely contact with the body, including the amount of leakage and potential contamination of clothes, equipment or contact with blood or body fluids;
- the susceptibility of individual people working in the premises;
- the severity of the disease(s);
- health surveillance and immunisation available for staff undertaking the task (i.e. whether prophylactic treatments are available).

HSE (2018)

5.3.1. The Management and Associated processes for the Management of a Patient Suspected of COVID-19

Novel coronavirus (COVID-19) is a new strain of coronavirus. Initial findings suggest that the main routes of transmission are via large respiratory droplets and direct or indirect contact with infected secretions. If the deceased was known to have been suspected or confirmed to have been infected with COVID-19 routine standard infection precautions are required.

The Use of Body Bags
Body bags are **not necessary** for cadavers where COVID-19 has been implicated in the death unless it is thought that there would be leakage in transit or the bodies are otherwise offensive.

Laying Out
Hygienic preparation of bodies involving washing of the face and hands closing the eyes and mouth tidying the hair and possible shaving the face is permissible. This includes plugging orifices

to prevent discharge or covering any wounds.

In some religious groups relatives expect to carry out the ritual preparation before burial and this may be permitted but they should be advised to wear gloves and a disposable apron and wash their hands afterwards.

Viewing the deceased may also be permitted: Infection Prevention and Control Guidance for Pandemic Coronavirus PDF.

All COVID-19 deaths will need to be reported via Datix. There is a specific category on Datix for reporting COVID-19 deaths. All COVID-19 deaths will be reviewed by the corporate safety huddle.

All COVID-19 related deaths require notification on the national COVID-19 Central Notification system. Registration of COVID-19 deaths will be undertaken by the Risk Team.

5.4. Infection Prevention and Control – Cleaning of Vacated Room and Items of Patient Equipment

Where there is no infectious risk identified, the normal cleaning schedule utilising normal approved cleaning products is required for all patient reusable equipment, bedroom or bed space.

When a deceased patient with a confirmed infectious risk has been removed by the mortuary staff or funeral director, the patients' bed area and any reusable equipment requires cleaning with the Trust approved disinfection product. The normal environmental cleaning schedule to be followed utilising enhanced cleaning – the use of Trust approved disinfectant product (e.g. Actichlor Plus) is required (also referred to as a terminal clean). This involves the affected rooms/area to be thoroughly cleaned utilising enhanced cleaning disinfectant product and may include changing curtains, cleaning soft furnishings and carpets.

5.5. Management of Waste

All waste produced should be disposed in accordance with the Trust Waste Management Policy.

5.6. Verification of Death

It is widely acknowledged that a registered health care professional, who has undertaken appropriate training/education and is confident and competent, can perform verification of death. However, certification of deaths remains the legal responsibility of the doctor who saw the patient in their last period of illness, including the patient's own GP or Coroner.

For additional information regarding verification and certification see the Procedure for the Verification of Death for Whitby and Malton Community wards and Granville Court and the Procedure for the Verification of Expected Death in the Community.

Unexpected deaths must be verified by a medical doctor (and usually a senior medical doctor). Unexpected deaths are defined as 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.

The verification of death will be documented in clinical records and will include the following information; date and time of occurrence, along with the name and contact details of the responsible practitioner.

5.7. Certification of Death

The law requires that:

“A registered medical practitioner who has attended a deceased person during his last illness is required to give a medical certificate stating the cause of death ‘to the best of his knowledge and belief’ and to deliver that certificate forthwith to the Registrar. The certificate requires that the doctor state the last date on which he saw the deceased person alive, and whether or not he saw the body after death. He is not obliged to view the body but good practice requires that if he has any doubt about the fact of death, he should satisfy himself in this way.”

(HMSO Report of the Committee on the Death Certification, and Coroners-Home Office, 1971)

Out of hours medical examiners can certify death where there is a cultural/religious requirement to bury, cremate or repatriate patients quickly (DH 2008). Medical examiners can also certify for reportable deaths where a post-mortem is not deemed necessary (DH 2008). The medical examiner (ME) is a primary care Trust-appointed but independent health professional who determines the need for coroner referral. For those who need a quick burial within 24 hours, this remains at the discretion of the local births and deaths registrar in each council and depends on the individual opening hours and on-call facilities.

If a patient is detained under the mental health act, the police must be informed. The body will be removed to a mortuary to await post-mortem.

Where a patient dies when detained under the Mental Health Act then the form “Statutory Notification about the death of a person detained or liable to be detained under the Mental Health Act 1983” must be completed. This will be undertaken in conjunction with the Legal Service Department.

5.8. Cultural and Religious Procedures following Death

Health care professionals need to be aware of the different religious and cultural rituals that may accompany the death of a patient. There are notable cultural variations within and between people of different faiths, ethnic backgrounds and national origins. For guidance see Caring for people of different faiths.

If the relatives or carers are not present at the time of death they need to be informed by a professional with appropriate communication skills (DoH, 2009) and offered support, including access to a spiritual leader or other appropriate person.

If the relative(s) or next of kin are not contactable by telephone or by the GP, it may be necessary to inform the police of the death.

Some families and carers may wish to assist with Last Offices, and within certain cultures it may be unacceptable for anyone but a family member or religious leader to wash the patient (Green and Green 2006). It may also be required for somebody of the same sex as the patient to undertake Last Offices (Neuberger 2004). Families and carers should be supported and encouraged to participate if possible as this may help to facilitate the grieving process (Berry and Griffie 2001).

5.9. Removal of the Deceased Patient

The family or carer will be provided with a bereavement package as per local arrangements.

The family or carer will be required to contact the funeral director as soon as possible after the person’s death so that they may support the family to make the necessary arrangements.

The removal of the deceased patient will depend upon whether mortuary facilities are available to the in-patient unit. Where mortuary facilities are not available, the funeral director should be informed and will remove the deceased.

It is important for staff to identify with the next of kin who the funeral director of choice is. If this is not undertaken, a cost may be incurred by the Trust if further intervention by another funeral director is required.

NHS trusts become responsible for the funeral arrangements of a person who dies in hospital when:

- no relatives are traced; or
- relatives are not able to afford the cost themselves and do not qualify for Social Fund Funeral Payments.

5.10. Managing Patient Belongings

This information is taken from the Trust's Patient's Property Procedure.

When an inpatient or resident dies, the following procedures should be observed:

- Clothing should be recorded in the property record by two members of staff, who should place the articles in black bags and attach a label with the client name and hospital number to each one.
- All valuables should be listed in a valuables record*.

*The Valuables Record should list the item with a brief description of the item and its condition that is completed by at least two people and signed/dated as a true record by both.

- The person in charge should check whether there are any outstanding valuables or items of clothing which have not previously been taken into custody or accounted for.
- The cash and valuables belonging to the deceased should be placed in safe keeping until it is established who the next of kin is.
- The deceased's cash and valuables should only be surrendered to the next of kin on completion of an Indemnity Form for Deceased Patients (Appendix B in the Patient's Property Procedure). The officer or manager has the responsibility for ensuring that it is done, in strict accordance with instructions from the Finance Department concerning matters of probate.
- If there is no next of kin to take on the responsibilities for the funeral arrangements/costs please speak to the Financial Services Department for advice on procedures.

In no circumstances should staff hand over valuables or cash to other relatives or friends of the deceased person.

5.11. Documenting Patient Death in Clinical Notes

Please refer to the Procedure for the Verification of Expected Death in the Community.

6. MONITORING AND AUDIT

Standards precautions, application in practice and clinical staff knowledge are included on the annual Infection Prevention and Control Environmental Audit. Elements of this policy also fall within the risk elements in the Essential Steps to Safe Clean Care Observational Tool which is undertaken within the Trust (Department of Health, 2006).

7. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

REFERENCES

- Berry, P. and Griffie, J. (2001) Planning for the actual death, in Textbook of Palliative Nursing (eds B. Ferrell and N. Coyle). Oxford University Press, Oxford. pp.382–394.

- Department of Health (2008) End-of-Life Care Strategy. Department of Health, London.
- Department of Health (2015) Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance
- Green, J. and Green, M. (2006) Dealing with Death: A Handbook of Practices, Procedures and Law 2nd ed. Jessica Kingsley Publishers: London.
- Health and Safety Executive (2018) Managing infection risks when handling the deceased Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation.
- Home Office (1971) Report of the Committee on Death Certification and Coroners. CMND 4810. HMSO, London.
- NHS National End of life Care programme in partnership with the National Palliative Care Nurse Consultants Group (2011) Guidance for staff responsible for care after death (last offices).
- NMC (2015) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates Nursing and Midwifery Council: London.
- Neuberger, J. (2004) Caring for People of Different Faiths. Radcliffe Medical Press, Abingdon.

RELATED TRUST POLICIES

- Mental Health Act Legislation and Associated Procedural Guidelines Policy, Appendix 13 Statutory notification about the death of a person detained or liable to be detained under the Mental Health Act 1983
- Standard Precautions Policy
- Policy for Medical Devices and Non-medical Devices and Equipment of High cost/volume for use in patient areas, management and procurement
- Waste Management Policy
- Procedure for the Verification of an Expected Death in Community
- Procedure for the Verification of Death for Whitby and Malton Community Wards and Granville Court
- Patients' Property Procedure

Appendix 1: Key Infections and Precautions

The causative agents for the key infections listed below have been arranged according to the most likely route of transmission, taking account of the activity when handling the deceased.

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can post-mortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Airborne Small particles that can remain airborne with potential for transmission by inhalation							
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes[2]	Yes[3]	Yes	Yes[3]
Middle East respiratory syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Severe acute respiratory syndromes (SARS)	eg SARS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Droplet Large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose or eyes)							
Meningococcal septicaemia (meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes[5]	Yes	Yes[5]
Flu (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes[5]	Yes	Yes[5]
Diphtheria	*Corynebacterium diptheriae*	2	No	Yes	Yes	Yes	Yes
Contact Either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes[5]	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	No[6]	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No[6]	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No[6]	Yes	Yes	Yes	Yes
Enteric fever (typhoid/ paratyphoid)	*Salmonella typhi/ paratyphi*	3	No[6]	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis*	3	No	Yes	Yes[4]	Yes	Yes[4]
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxin-producing *E.coli* (eg O157: H7)	3	No[6]	Yes	Yes[4]	Yes	Yes[4]

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can post-mortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Contact Either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired immune deficiency syndrome (AIDS)-related illness	Human immunodeficiency virus	3	No	Yes	Yes[7]	Yes	Yes[7]
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[8]	No	No
Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes[7]	Yes	Yes[7]
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	Specifically Lassa fever, Ebola, Marburg, Crimean-Congo haemorrhagic fever viruses	4	Yes[9]	No	No	No	No
Contact Either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							
Transmissible spongiform encephalopathies (eg CJD)	Various prions	3	Yes	Yes	Yes[10]	Yes	No

Key

Red Minimise procedures or handling of the deceased

Yellow TBPs are necessary when carrying out procedures or handling the deceased

The highlighted areas indicate an increased level of risk associated with the infection to workers (with areas in red posing increased risk) and therefore require additional control measures when handling the deceased.

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is, or is likely to be, leakage of body fluids.

[2] With appropriate measures to deal with potential release of aerosols (eg place cloth or mask over mouth when moving the deceased).

[3] With appropriate measures to deal with aerosol-generating procedures.

[4] With measures to minimise environmental contamination (because of low infectious dose; ie the amount of pathogen or number of bacteria required to cause an infection is low).

[5] With appropriate measures to prevent exposure of mucosal surfaces (eg a physical barrier to protect eyes, mouth and nose, such as a facemask or visor).

[6] Although illness may have increased likelihood of leakage of body fluids.

[7] With appropriate robust measures for the use of sharps (eg minimise use or use safer sharps devices).

[8] Before undertaking a procedure, the rationale for a post-mortem should be carefully considered where anthrax infection is suspected, particularly where examination may increase the potential for aerosol generation.

[9] With double body bag.

[10] With appropriate measures to minimise percutaneous injury and contamination of work area, and to help with decontamination (eg high-level sharps control or dedicated equipment).

Health and Safety Executive (2018) Managing infection risks when handling the deceased.

Appendix 2: Hazard Notification Sheet

1	**Name of deceased**			
2	**Date and time of death**			
3	**Source (hospital, ward or other)**			
4 Infection risk from the deceased[1]				
4a	Does the deceased present an infection risk? (Ring as appropriate)			
	Yes	Suspected	None suspected	
4b	If yes, what are the likely routes of transmission? (Ring all that apply)[2]			
	Airborne	Droplet	Contact	
4c	Infection (if permitted to disclose)[3]			
4d	Provide any relevant information to enable the deceased to be handled safely[4]			
5 Condition of the deceased[5]				
5a	Is the deceased leaking body fluids? Please provide details			
5b	Have accessories that present a risk of sharps injury been removed?			
5c	If yes, have the puncture points been covered or sealed?			
5d	If no, please provide details and location			
5e	Does the deceased have an implantable device? (Ring as appropriate)			
	No	Yes and switched off	Yes but not switched off	
5f	If yes, please provide details and location			
5g	Was the deceased receiving radiotherapy? (If yes, please provide details)			
6	**Signed**[6]			
	Print name			
	Institution			

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc. Act 1974). This form provides one means of sharing the pertinent information.

Notes

1 Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or

where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

2 When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3 If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4 In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (e.g. embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

5 In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, e.g. sharp medical devices or implantable devices (e.g. pacemakers), their location and whether they need to be removed.

6 In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (e.g. community setting), the doctor with knowledge of the deceased's condition is asked to sign.

Health and Safety Executive (2018) Managing infection risks when handling the deceased