



August 2025

Care after Death

5.2 addition

Guidance for staff responsible for care after death

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Version Control

Date	Version	Reason
13 March 2024	5	Medical Examiner role added References to COVID removed. References updated.
22 October 2024	5.1	Changes made to reflect the Overview of Death Certification reforms (August 2024); - it will be statutory (in England and Wales) for all non-coronial deaths to be scrutinised through the medical examiner system (20) - a medical practitioner will be eligible to be an attending practitioner and complete a Medical Certificate of the Cause of Death (MCCD), if they have attended the deceased in their lifetime and know the cause of death (21) - Additional lines of enquiry (22)
19 December 2024	5.1	Removed from page 8: "The death can be verified even if the doctor has not seen the patient in the previous 28 days."
19 December 2024	5.1	Removal of "The death can be verified even if the doctor has not seen the patient in the previous 28 days" on Page 8.
4 August 2025	5.2	Paragraph 45 added in response to the <u>Independent Inquiry into the issues raised by the David Fuller case: phase 2 report</u>
29 September 2025	5.2	Text added in to Page 3: Uncontrolled when printed. This document is maintained electronically. The printed version of this document is not controlled and may be out of date. For the most current and official version, please refer to the Hospice UK website: Care After Death guidance Hospice UK

Foreword

We welcome readers across the four nations to this fifth edition of "Care after death: guidance for staff responsible for care after death."

The need to give personalised compassionate care does not end when the person has died but continues with care after death, including supporting friends and families into bereavement. We recognise that each death is a uniquely individual experience that reflects many aspects, such as the illness the person has experienced, their personal preferences if a preference could be expressed, and the social, cultural, spiritual, and religious aspects of the person's life.

We thank all the individual's representing organisations who have contributed so willingly and helpfully to this guidance, and we look forward to continuing to work with you to keep this guidance current. We would recommend that commissioners of education and services consider the importance of this guidance in ensuring compassionate care for those who have died and those who are bereaved.

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National
Nurse Consultant Group
Palliative Care



The Royal College of Pathologists
Pathology: the science behind the cure



Royal College
of Nursing

Glossary

Bariatric – a person who requires non-standard equipment for moving, handling, and transferring due to their weight, physical size, shape or width.

Care after death – a term used in place of “last offices” and more befitting of our multi-cultural society, reflecting the variety of tasks of care at the time of death, including supporting the family and those identified as being of most importance to the deceased.

Cold room – a room chilled to preserve the body, enabling key contacts/carers to spend extended amounts of time with the deceased. Usually located in hospices.

Coroner – independent judicial officer appointed by local authority in England, Wales or Northern Ireland to investigate the cause and circumstance of a death. This includes where there is reasonable suspicion the death was violent or unnatural, or cause of death is unknown, or the death occurred whilst in custody or state detention, or the deceased was not seen by a doctor in the 28 days before they died.

Debrief – post-incident opportunity to discuss the event with support from another colleague or as a team, which provides the chance to talk about the emotional impact of the incident.

Endotracheal (ET) tube – a catheter that is inserted into the trachea to establish and/or maintain the airway and ensure the adequate exchange of oxygen and carbon dioxide.

Expected death – An expected death is the result of an acute or gradual deterioration in a patient’s health status, usually due to advanced progressive incurable disease. The death is anticipated, expected and predicted. It is anticipated in the circumstances where advance care planning and the consideration of DNACPR will have taken place.

Family Liaison Officer (in Prison) – supports key contacts with help to obtain answers to their questions regarding the circumstances of a death in prison and provides a clear point of contact with the Ombudsman’s office.

Fixion nail – a self-locking expandable intramedullary nail system requiring no screws or fixings, commonly used to pin together bones that have been fractured. Once in place, the nail is expanded to lock hydraulically. There is a risk of explosion during cremation. The presence of a fixion nail should be in the patient notes. However, it is the responsibility of the doctor completing the cremation form 4 to notify of fixion nails. The mortuary team are

not trained in their removal, so as long as the funeral directors are made aware prior to cremation, this should suffice.

Implantable cardiac defibrillator - a device indwelling in the chest that delivers a therapeutic dose of electrical energy to a heart affected by an arrhythmia.

Key contact – a person identified as the central individual to communicate with. This could be a power of attorney for health and welfare, or a court appointed deputy, or an Independent Mental Capacity Advocate (IMCA). It could also be, for example, a husband, wife, son, or daughter; or a significant other, for example, a partner, friend, or neighbour.

Medical Certificate of the Cause of Death (MCCD) - a document given to key contacts to enable them to register the death and obtain the death certificate.

Medical Examiner - Senior medical doctor trained in legal and clinical elements of the death certification process. Appointed in England or Wales to be independent of the case when undertaking scrutiny of the circumstances of death. From April 2024, the role of the Medical Examiner (ME) will be extended to include an oversight of all proposed causes of death. There will also be a new MCCD to include the details of the ME who is scrutinising the cause of death, the deceased' ethnicity and details of any medical devices or implants.

Medical Examiner Officer - Supports the medical examiner in their role in scrutinising the circumstances and causes of death, and is a point of contact and source of advice for relatives of the deceased, healthcare professionals and coroner and registration services

Nursing Associate (NA) - a member of the nursing team (Band 4) who undertakes a nursing support role, provides care and support to patients and service users. Regulated in England by the Nursing and Midwifery Council (NMC) since July 2018.

Personal care after death - the physical preparation of the deceased after death and before transfer to the mortuary or funeral director.

Personal Protective Equipment (PPE) - PPE is equipment that will protect the user against health or safety risks at work including risks posed by micro-organisms including COVID-19. It includes disposable gloves, apron and surgical masks, and for aerosol generating procedures (AGP), includes eye protection, gowns and shoe protection too. Worn correctly and used in conjunction with other practices such as hand hygiene and risk assessment PPE reduces the risk of infection to the wearer.

Procurator Fiscal - appointed by the Crown Office & Procurator Fiscal Service (COPFS) in Scotland to investigate sudden, suspicious or unexplained deaths. Acts on instructions of the Lord Advocate who has the responsibility in Scotland to investigate any death, which requires further explanation.

Registered Nurse (RN) - a Registered Nurse who holds a valid registration with the Nursing and Midwifery Council (NMC) on the relevant part of the register.

Schwartz rounds - provides a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare¹. The purpose is to understand the challenges and rewards of providing care, not for solving problems, instead for providing staff with support and role model compassion².

Suspicious death - a death where crime is suspected, where an accident has occurred, when death conflicts with the medical prognosis or when a death occurs because of trauma in a medical setting.

Sudden or unexpected death - An unexpected death is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present, there is an expectation that resuscitation will commence³.

There is further clear guidance from the Resuscitation Council UK for circumstances where a patient is discovered dead and there are signs of irreversible death⁴. In such circumstances, the RN may make an informed clinical judgement not to commence CPR, for example clear signs of rigor mortis. The RN must be able to articulate and document clearly their actions and reasoning.

Introduction

1. This guidance is written to support the care of the deceased adult. There is concurrent guidance available for the care of the deceased child^{5,6} and for the death of a baby⁷. Staff providing the care of the deceased in all settings, including in the deceased's own home, will require clear guidance, training, and PPE to protect them whilst providing the care⁸. This guidance has relevance to all four nations (England, Wales, Scotland, and Northern Ireland) and respects both individual law and the evolution of clinical practice⁹. However, there is recognition that each of the four nations may need to tailor the guidance.
2. The guidance relates to other concurrent work:
 - Previous edition of the Care after Death guidance¹⁰
 - 6th Edition Registered Nurse Verification of Expected Adult Death¹¹¹²¹³
 - Academy of Medical Royal Colleges: code of practice for the diagnosis and confirmation of death¹⁴
 - Reforming the Coroner and Death Certification Service¹⁵
 - National Medical Examiners good practice guidelines (England and Wales)¹⁶
 - An overview of the death certification reforms ¹⁷
 - Death Certification Review Service (Scotland)¹⁸
 - Leadership Alliance for the Care of Dying People – One chance to get it right¹⁹
 - Bereaved families' experiences of organ and tissue donation, and perceived influences on their decision-making²⁰
 - Coronavirus act expiry: Death certification and registration easements from 25 March 2022.
3. There is a trend for more people dying outside the acute Trust, in their own home, (e.g. in care homes, private residences) and in institutions, (e.g. hospices, prisons and mental health settings).
4. In this document the term 'key contact' is used and represents family, and those people identified as being of most importance to the dying/deceased person. The shortened version is used for brevity and ease of reading. In line with the Mental Capacity Act 2005, the legal role given to people holding a Lasting Power of Attorney for health and wellbeing (LPA) is recognised. With respect to organ and tissue donation, medical practitioners should

make every effort to establish the decision of the potential donor during his or her lifetime and support the fulfilment of this decision.

5. Deceased organ donation in the UK currently only occurs in intensive care units and, to a much lesser extent, in emergency departments. In the financial year to 31 March 2024, there were 1510 organ donors compared to approximately 662000²¹. In England and Wales, adults who have not opted in or out of donation can have their consent deemed^{22 23}. The Organ and Tissue Donation (Deemed Consent) Act (Northern Ireland) 2022 was passed by the Northern Ireland Assembly on 8 February 2022 and received Royal Assent on 30 March 2022. Secondary Legislation was passed on 27 February 2023 and received Royal Assent on 28 February 2023. The new law came on to effect on 1 June 2023. With post-mortem examination, consent needs to be sought, unless the post-mortem examination is authorised by the coroner in England, Northern Ireland and Wales, and procurator fiscal in Scotland, where consent is not required²⁴.
6. The term 'deceased' is used to represent the deceased person and 'viewing' is used to represent the visiting of the deceased person by their key contacts. The shortened version is used only for brevity and ease of reading. The importance of personalising care is recognised. It is also noted that the same words can mean different things to professionals and key contacts. We urge professionals to use language that is meaningful to key contacts.
7. It is also recognised that medical colleagues use the term 'confirmation of death'²⁵ rather than 'verification of death', as we have used in this document and related guidance²⁶. We also note that our medical colleagues find the term 'confirmation' helpful when discussing the recognition of death with families particularly in the context of organ donation²⁷. We look forward to working with our medical and wider multi-disciplinary colleagues as discussed²⁸ to agree both the processes for verifying death in all clinical circumstances and the terminology. We note that Scotland has already moved to the term 'confirmation of death'²⁹.
8. The flow diagram in Appendix 1 is intended as both a summary and for teaching purposes. It shows that care after death (including personal care after death) is the first stage of a process that involves a range of professional groups. This process of care leads ultimately to cremation, burial, or repatriation of the deceased. Professionals involved in care after death include doctors, nurses, healthcare assistants, mortuary staff, hospital porters, ambulance staff, bereavement officers, specialist liaison workers, for example, those who

support individuals with learning disabilities and their key contacts, police, social care staff, funeral directors, pathologists, coroners, procurators fiscal, healthcare chaplains and faith leaders. Coordinated working between these individuals and organisations is vital if the process is to run smoothly. The family, and those people identified as being of most importance to the deceased person, are the only people who navigate this entire process. We urge professionals to be both mindful of all steps in the process, and their part in the coordination of care to benefit the bereaved experience of care after death.

9. When a person dies an expected death, in their own home without family or a key contact, it is vital that care agencies understand the role they play in place of the family, or key contact. This is regardless of whether the care agency is funded by the NHS, Social care or privately. There is a responsibility to ensure that the appropriate professional is called to verify the death, the GP practice is notified so they can arrange discussion with the Medical Examiner (ME) and the issuing of the MCCD, the deceased's dignity is maintained, the property is secured and there is a presence with the deceased until the funeral director can collect them. This does not need to be the care agency, but adequate arrangements must be made prior to leaving the deceased.
10. When a person dies and they have no known family or they are unclaimed by their relatives and/or they have no remaining estate to pay for a funeral, they are entitled to a public health funeral of burial or cremation. In the UK, every local authority has a statutory duty to provide appropriate funeral arrangements³⁰. The local authority will endeavor to contact the person's closest relatives through any contact details or paperwork left by the deceased. There is also a nationwide tracing service, and the Salvation Army can also attempt to identify lost relatives³¹.
11. Whilst care after death in the community is usually undertaken by key contacts, it is important for staff to understand the role of community nursing and palliative care teams in supporting key contacts during this time, as appropriate. Some cultures may have people from their local faith community attend and help wash and prepare the deceased. Some key contacts may utilise the services of a death doula³², a non-medical professional who makes themselves available to the key contacts for support before, during and after a person's death.
12. Care after death includes:
 - Respecting the spiritual, religious, and cultural wishes of the deceased and their key contacts, where possible, should be taken into consideration and ensuring legal

obligations are met

- Ensuring timely verification of death
- Preparing the deceased for viewing, where appropriate, and supporting the key contacts
- Offering key contacts who are present the opportunity to participate in the process and supporting them to do so
- Facilitating people's wishes for organ and tissue donation where it is possible. Organ donation is only possible from intensive care units and emergency departments and can only be organised before the person dies in donation after circulatory death (DCD) or before the withdrawal of organ support in the case of donation after brain death (DBD). However whole-body donation to science and tissue donation is possible after death³³. Cornea donation can happen up to 24 hours after death and can take place in hospitals, hospices, and funeral homes³⁴.
- Ensuring, where relevant, that key contacts are informed about the need for post-mortem examination and given information about possible organ and tissue retention and disposal methods
- Preparing the deceased for transfer to the mortuary or the funeral director's premises
- Ensuring that the privacy, dignity, and respect of the deceased is maintained at all times
- Ensuring that the health and safety of everyone who comes into contact with the deceased is protected
- Returning the deceased's personal possessions to their key contacts
- Use of appropriate PPE in line with UK Health Security Agency guidance
- Appropriate disposal of controlled drugs³⁵. This is of particular importance when a person dies in their own home.

Legal aspects

13. In this document, the term 'coroner' is used to represent the role of the coroner in England, Wales and Northern Ireland, and the procurator fiscal in Scotland. The shortened version is used only for brevity and ease of reading. It is essential to comply with legal requirements. See Appendix 2 for deaths that require an investigation by the coroner. It is useful to note that 34% of all deaths in 2023 were reported to the coroner

in England and Wales, the lowest level since the start of the annual time series in 1995³⁶. An estimated 11,000 deaths are reported to the Crown Office and Procurator Fiscal Service (COPFS) in Scotland every year³⁷ which, for 2019, equates to approximately 19% of all deaths in Scotland³⁸. In Northern Ireland there were 15,758 deaths in 2019 of which 28% were referred to the coroner's office³⁹.

14. All staff caring for the deceased need to ensure they are familiar with deaths that require such a referral, as this will facilitate the correct personal care and enable staff to prepare the key contacts both for a potential delay in the processing of the MCCD and the possibility of a post-mortem examination.
15. When there is a death of a person detained under the Mental Health Act or in custody, it must be reported to the coroner and will be subject to a coroner's inquest, or procurator's fiscal investigation if in Scotland. Such deaths will always be investigated by the coroner and police, and for those in custody by the Police Prisons Officer. A specialist forensic post-mortem examination is likely to be undertaken. Where the person was detained, or was liable to be detained, under the Mental Health Act at the time of death, the provider must notify the Care Quality Commission under Regulation 17 of the Health and Social Care Act 2008⁴⁰. The team responsible for the deceased's care usually completes forms. For all expected deaths in prisons, the Prison and Probation Ombudsman will investigate the death, and the findings will be shared with the coroner prior to the inquest.
16. Guidance is available on the care of vulnerable adults⁴¹. If a safeguarding issue becomes apparent after death, clearly documented concerns should be raised with social services, the police, and the coroner in line with local processes and guidance.
17. Where the person had an illness that requires referral to the coroner, (e.g. mesothelioma) but dying was anticipated, it is not necessary to involve the police. Referral to the coroner does not automatically require a post-mortem, but a post-mortem can be useful to assess the extent of the disease or other factors contributing to death.
18. The consultant in charge of the care remains ultimately responsible for the deceased whilst under hospital/hospice care, and the general practitioner (GP) practices in primary care.

19. As part of the reforms being introduced from September 2024, a medical practitioner will be eligible to be an attending practitioner and complete an MCCD, if they have attended the deceased in their lifetime. The attending practitioner will propose a cause of death, if they can do so, to the best of their knowledge and belief ⁴².
20. From September 2024 it will be statutory (in England and Wales) for all non-coronial deaths to be scrutinised through the medical examiner system. This will involve scrutiny of the medical notes by a medical examiner to agree the proposed cause of death through discussion with the certifying doctor, discussion of the cause of death with the key contact, and to establish if they have any concerns prior to the MCCD being released. In Scotland, the Certification of Death Act (2011) ensured a national review system for checks on MCCD accuracy.
21. The certifying medical practitioner has overall responsibility for identifying and communicating the presence of any implanted devices or radioactive substances. They are also responsible for identifying the appropriate person to deactivate and remove implants, to liaise with the appropriate medical physics department regarding radioactive treatments and to advise mortuary staff and funeral directors. For information required by mortuary staff and funeral directors see Appendix 3.
22. The death certification reform⁴³ in September 2024, will include numerous additional lines of enquiry for the death process. Firstly there is extension to the ME role for the oversight of all proposed causes of death; secondly a new MCCD with more comprehensive information including details of the ME overseeing the process, the deceased's ethnicity and details of any medical devices or implants; thirdly development of an electronic version of the MCCD, fourthly the registrar no longer needing to refer deaths to the Coroner as the ME will now undertake this role and finally, due to the additional scrutiny undertaken of each death, the cremation form 4 will no longer be required nor the regulatory requirement for a medical referee scrutiny prior to cremation. In Scotland, the Certificate of Registration of Death (Form 14) is required for both cremation and burial and is issued by the Register Office once the death has been registered with the MCCD (Form 11)⁴⁴. All four nations have updated their registration of death processes to support electronic/remote registration⁴⁵.

Care after death

Responsibility for care after death

23. If present at the actual time of death, the registered nurse, doctor, ambulance clinician or appropriately trained registered professional⁴⁶ needs to record the time, who was present, the nature of the death, and to record their own name and contact details in the nursing, medical or ambulance documentation. The official time of death is when the verification of the death takes place.
24. They will need to record details of any relevant devices such as pacemakers and intrathecal devices, or Fixion nails. If the deceased person has a cardiac defibrillator which has not yet been deactivated⁴⁷, local policy should be followed, and steps taken to ensure it is deactivated before the person is moved to the mortuary or funeral director. None of these devices prevent cremation but they will need to be removed prior to cremation by appropriately trained mortuary staff or funeral director⁴⁸.
25. If a carer is present with the person in the home / care home then they should be advised to call the GP practice (in hours) or 111 out of hours to ensure appropriate support and a plan to verify the death. If the ambulance service has been called and attended the deceased, they will have verified the death.
26. The person present needs to be aware of any pertinent details in the deceased's Advance Care Plan (ACP) that relates to care after death, and to act on this, as usually these wishes are time critical. Such examples are:
- Spiritual, religious, and cultural preferences especially related to urgent release for burial or cremation⁴⁹. Where available, advice from the spiritual care or chaplaincy department can be sought to support with the wishes of the deceased and their key contacts
 - Wishes for repatriation: The local funeral director will advise and address the specific feasibilities⁵⁰.
 - Whole body donation: Medical schools are now looking to gradually resume donations services. However, there may be limitations for some time and donors should ensure they have alternative funeral plans
 - Wishes for organ and tissue donation.

Referral to the coroner

27. For deaths that require referral to the coroner, please see Appendix 2. If a person was found unexpectedly deceased in their own home by a carer, then the police should be called. They would then take custody of the deceased and ensure the safety of the home. Please note that COVID-19 is a notifiable disease but not reportable to the coroner; further information of notification of infectious diseases is also found in Appendix 2. The following details may be required when reporting a death to the coroner:

- The professional's telephone contact number
- The deceased's name, address, date of birth
- GP details
- Key contact name(s), contact details and relationship to the deceased
- Date and time of death
- Details of the person who verified death
- Details of what happened leading up to the death, including who was present at the death.

28. If the case is being referred to the coroner because the cause of death is unknown or the death is unexpected, seek advice before moving or removing anything that might be relevant to establishing the cause of death. It is anticipated that mental health and prison services would have robust policies on unexpected death as all deaths would be referred to the coroner and would need police attendance at an undisturbed scene of death. If key contacts have any concerns about the death these should also be documented (and in this instance it is important to maintain the deceased body and environment and seek advice from the coroner). The ME process will now ensure timely referral to the Coroner for any deaths that require further investigation.

Verification

29. When death occurs, inform the medical practitioner primarily responsible for the person's care. In acute trusts it is helpful if verification occurs within one hour. In other settings it is helpful if it takes place within four hours. Verification of death needs to be completed by a doctor⁵¹, appropriately registered nurse⁵² or ambulance clinician⁵³ before the deceased is transferred from the care setting^{54, 55}. In Scotland it is recognised that any registered professional can undertake this act of care with appropriate training⁵⁶. It is important to note that due to Article 2 of the Human Rights Act 1988⁵⁷, and subsequent inquests, prisons

are exempt from verification of death by registered nurses.

Issuing of the Medical Certificate of the Cause of Death (MCCD)

30. **Verification** of death is the process of **confirming the fact of death**. It is different from certification of the cause of death. **Certification** is the process of **issuing a MCCD**, and this is the responsibility of a medical practitioner.
31. For hospitals in England and Wales, a medical examiner will be present and, there may be a delay before the MCCD is issued due to review and scrutiny of the proposed cause of death to ensure overall accuracy of the MCCD⁵⁸.

Issuing of the Death Certificate (Certified copy of an entry of death)

32. The key contact notifies the registrar by telephone or email to begin the death registration process. The ME office or Coroner will inform the Registrar when the certification process is complete and will email the MCCD. The key contact or whoever is registering the death must book an appointment using the online or telephone booking system, to attend that registrar's office to register the death in person. The police can be of assistance in locating key contacts and breaking significant news if the care organisation are unaware of who this is.

Communication – with key contacts

33. After the death has been verified, always provide the key contact with information on the processes to be followed after a death. In hospital this would usually be to call the bereavement office and in the community it will be the GP surgery. Where a hospital does not have a bereavement office, and in hospices and care homes, the key contact will be instructed to call the ward or care home manager, respectively. The bereavement office, ward manager, hospice, care home or GP surgery will be aware of bereavement agencies available to support key contacts in their local area and provide help in a supportive way. When the MCCD is completed, the ME or Coroner's officers will contact the key contact to discuss the cause of death. If the ME wishes to change the order of the causes of death documented on the MCCD or discuss any point of clarification, they will contact the medical professional completing the certificate. This may cause an added delay.

Communication – with professionals

34. It is vital that processes are in place to protect confidentiality, and that these continue after death. However, this does not prevent the use of sensible rules to safeguard the health and

safety of all those who may care for the deceased⁵⁹.

35. There needs to be clear communication regarding any infection risk and the presence of implantable devices to mortuary staff and funeral directors. If the deceased had a notifiable infection there is detailed guidance available, including on infections requiring the use of a body bag⁶⁰. All those who previously cared for the deceased need to be notified of the death.

Responsibility for personal care after death

36. In NHS hospitals, hospices, and private nursing homes the personal care after death is the responsibility of a registered nurse, although this, and the packing of the deceased's property, may be delegated to a suitably trained healthcare support worker wearing appropriate PPE. The registered nurse is responsible for identifying the deceased, being aware of when to refer to the coroner and communicating accurately with the mortuary or funeral director (in line with local policy).

37. In care homes without a registered nurse, the home manager is responsible for ensuring that professional carers are trained appropriately and that they have the relevant competence for the role. In prisons, personal care after death is the responsibility of the prison service (not prison healthcare), and all property is left for the family liaison officer to return to the key contact.

38. It is essential to update and organise the medical and nursing records⁶¹ as quickly as possible so they are available to the bereavement team and other interested professionals, such as the medical examiner and pathologists.

Time requirements and viewing

39. The personal care after death needs to be carried out within two to four hours of the person dying, to preserve their appearance, condition and dignity. Tasks such as laying the deceased flat (while supporting the head with a pillow) and preparing the deceased need to be completed as soon as possible within this time. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four to six hours of death is optimum⁶².

40. All key contact should be offered the opportunity to view the deceased and there is evidence that, even in traumatic circumstances, key contacts found this helpful⁶³. Viewing can occur in acute hospitals or some hospices or later at the Funeral Directors.

41. Key contacts should be guided on how to support children and young people who are also bereaved and specific information on viewing a body with a child^{64 65}.

Environment

42. The deceased needs to be cared for with dignity. It had been suggested that in hospitals such factors helping to contribute to this were a single room that had a feeling of homeliness, informal gathering spaces where key contacts can meet and confer, guest rooms for key contacts to stay and appropriate areas for viewing. It is important that the deceased's spiritual, religious and cultural wishes are attended to⁶⁶ and that the attitudes and behaviour of staff are respectful and reassuring of the care provided to the deceased; both to bereaved carers by phone (even if they are not physically present), and also to other members of staff, e.g. porters.

43. If the deceased dies an expected death in their own home, then those present – either families or care agency staff – need to ensure the dignity of the deceased is maintained. If the person dies outside of their bed / sofa space, they can, with assistance, be returned safely to the bed / sofa and their bodies covered until the death can be verified.

44. Residents in communal settings, such as care homes and prisons, have often built significant relationships with other residents and members of staff and they will need to be informed of the death. Compassionately consider how to address their need to know of the death within the boundaries of confidentiality. If the person has died in an environment where other people may be distressed by the death then inform them sensitively, using relevant resources as appropriate, that the person has died e.g. those produced to assist those with learning disabilities⁶⁷. Be careful not to provide information about the cause and reason for death. Consider signposting to bereavement support in these settings

Security

45. While NHS providers are required to comply with mandated safety and security controls for mortuaries and/or body stores, including keypad locks, swipe access cards and CCTV monitoring, in a hospice setting it is recommended that there is a standard operating procedure (SOP) regarding care of the deceased which includes security measures to protect their dignity and safety which may include CCTV monitoring. Any temporary or externally commissioned body store should meet these same security and governance standards.

Further recent recommendations from the Fuller report (2025)⁶⁸ also suggest the introduction of auditable access control to the area where deceased people are kept and minimise unaccompanied access of non-permitted staff or contractors, if possible. Whilst in Scotland, the guidance on Care After Death⁶⁹ does not specifically include security of the deceased, there is guidance⁷⁰⁷¹ for the NHS Mortuaries which details the need for strict security and stated the private and third sectors including hospices should adopt the standards.

Mementoes

46. Mementoes or keepsakes, (for example, locks of hair, handprints, etc.) may be offered and taken at the time of care after death. Funeral Directors can also provide this service.

Packing property

47. Property should be packed, showing consideration for the feelings of those receiving it and in line with local policy. Valuables should be placed in a valuable's property envelope.

48. Clothes that are contaminated or soiled should ideally, with key contact consent, be disposed of but can be packed into property bags and stored in a clean area to return to the key contact if desired.

49. Record all aspects of care after death in locally relevant documentation and identify the professionals involved.

Disposal of controlled medicines

50. It is expected that organisations, e.g. hospitals, hospice, care homes, have the appropriate procedures to safely dispose of controlled medicines. In the home setting family and key contacts should be advised to call the local pharmacy to arrange the return and safe disposal of controlled medicines. If there is no family or key contact, then the district nursing team or palliative care team should arrange for the collection and safe disposal at a local pharmacy in line with national guidance.

Transfer of the deceased from the place of death to the mortuary or funeral director

51. The privacy and dignity of the deceased on transfer from the place of death is paramount. Each organisation involved is responsible for ensuring that the procedures adopted to

transfer bodies, including those who are bariatric, respect the values of personal dignity, and these are incorporated in the design of the concealment trolley and the way the deceased is covered. The deceased may be transferred in a bed with an appropriate cover or concealment trolley. It is not recommended to transfer the deceased in ways that might make them appear alive to others, e.g. with an oxygen mask in situ. In community settings a funeral director will usually undertake transfer, although on rare occasions the deceased's executor (generally a key contact) may also do this.

Personal care after death

Equipment to be considered

52. It is essential to be well prepared before carrying out the personal care of the deceased. Thoughtful consideration should be given for the equipment needed to undertake the procedure with respect and dignity for the person, ensuring all equipment is gathered prior to undertaking the personal care of the deceased.

- Personal Protective Equipment
- Clean bed sheets
- Shroud or clean clothing for the deceased
- Soap and towels (or equivalent)
- Mouthcare equipment
- Brush or Comb
- Continence Pads
- Dressings
- Tape
- Name bands
- Mortuary label (or equivalent)
- Valuables envelopes and sealing plastic bags

Deaths requiring coroner involvement

53. Where the death has been referred to the coroner, there will be some parts of the personal care after death that cannot be carried out, and this will depend on the reason for referral.

54. **Forensic investigation referral:** When the death is being referred to the coroner as the

circumstances surrounding the death give rise to suspicion, there should be minimal contact with the body. Leave all drains, tubes, intravenous (IV) cannulae and lines in situ and IV infusions clamped but intact (this includes syringes with controlled drugs from syringe pumps). Leave any urinary catheter in situ with the bag and contents. Do not wash the body or begin mouth care in case this destroys evidence. Continue using universal infection control measures to protect people and the scene from contamination. Mortuary staff can provide guidance on this at the time of death. Ensure the cardiac defibrillator is deactivated.

55. **Cause of death referral:** When the death is being referred to the coroner to investigate the cause of death, but where there are no suspicious circumstances, then leave IV cannulae and lines in situ and catheters spigotted. Infusions and medicines being administered prior to death via pumps can be taken down and disposed of, according to local policy, but must be recorded in nursing and medical documentation. The contents of catheter bags can be discarded according to local policy. Leave the ET tube in situ as cutting the tube deflates the balloon holding the tube in position. The increased mobility may enable the ET tube to become displaced during the handling of the body and any possibility of movement will lead to confusion should the coroner need to investigate this through post-mortem examination. Personal care can then be given as for deaths without coroner involvement. Ensure the cardiac defibrillator is deactivated.

Deaths without coroner involvement

56. Particularly in the home setting, some key contacts/carers may wish to assist with the personal care. Prepare them sensitively for changes to the body after death and be aware of manual handling and infection control issues. Ensure the cardiac defibrillator is deactivated.
57. Carry out all personal care of the deceased after death in accordance with safe manual handling guidance. It is best practice to do this with two people, one of whom needs to be a registered nurse, nursing associate, or a suitably trained person.

Procedure: personal care after death

58. It is important to note that during this procedure, consideration must always be given to any care related to the deceased's spiritual, religious, and cultural needs.

ACTION	RATIONALE
Adopt standard infection control precautions.	To ensure protection of the person carrying out the personal care from cross-contamination.
Lay the deceased on their back, adhering to manual handling policy; straighten their limbs, (if possible) with their arms lying by their sides. Ensure the person is appropriately covered with a clean sheet. If it is not possible to lay the deceased flat due to a medical condition, or rigor mortis, then seek guidance from the mortuary staff or funeral director. The mortuary staff and porters, or funeral directors (depending on place of death), should be alerted if the deceased is bariatric.	To maintain the deceased's dignity, ensure the deceased is lying straight prior to rigor mortis which occurs 2-6 hours after death. To maintain the deceased's privacy and dignity. Alternative transportation may be required. To ensure they have the appropriate equipment to transfer the deceased.
Leave one pillow under the head.	Supports alignment and helps the mouth stay closed.
Close the eyes by applying light pressure for 30 seconds. This also applies when the deceased is donating their corneas. If the eyelids fail to close, then explain sensitively to the key contact/carers that the funeral director will resolve the issue.	To maintain their dignity, and for tissue protection in case of corneal donation

ACTION	RATIONALE
Do not apply tape over the eyelids.	Tape can mark the skin.
Tidy the hair as soon as possible after death and arrange into the preferred style, (if known). A lock of hair as a memento may be offered. Place in a plastic bag and seal.	To guide the funeral director for final presentation.
Clean the mouth to remove debris and secretions. Clean and replace dentures as soon as possible after death. If they cannot be replaced send them with the deceased in a clearly identified receptacle.	For hygienic reasons. To retain the facial shape of the deceased. The funeral director will likely be able to secure in place.
Where the jaw may need additional support, place a small pillow or rolled up towel under the chin. Do not bind the jaw with bandages. Some people have jaws that will never close; notify the mortuary staff or funeral director if this is the case.	To close the mouth maintaining the facial shape for the deceased's dignity. This will leave pressure marks on the face.
Do not shave the deceased person. Usually, the funeral director will do this. Be aware that some faith groups prohibit shaving.	Shaving a deceased person when they are still warm can cause bruising and marking which only appears days later.
Drain the bladder by gently pressing on the lower abdomen for 30 seconds and collecting the urine in a receiver, or catheter bag where a urinary catheter is in situ.	The body can continue to excrete fluids after death.

ACTION	RATIONALE
Remove catheter bag and spigot any urinary catheters, (if still in situ). Pads and pants can be used to absorb any leakage of fluid from the urethra, vagina or rectum. Do not pack.	To prevent fluid leakage.
Clamp any drains, and intravenous or subcutaneous lines still in situ. Remove any connected infusion lines and infusions.	To prevent leakage.
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. If the body is leaking profusely then take time, pre-transfer to the mortuary or funeral home, to address the problem. Ensure mortuary staff and funeral directors are informed of any potential for profuse leakage.	Avoid strongly adhesive tape on any occlusive dressing as this can be difficult to remove at the funeral directors and can leave a permanent mark. To enable appropriate positioning of the deceased in the refrigeration areas.
Wash the deceased, unless requested not to do so for spiritual/religious/cultural reasons, or	For hygienic and aesthetic reasons. Respecting the spiritual, religious, and cultural preferences of the deceased.

ACTION	RATIONALE
the death is being referred to the coroner. Key contacts and/or carers may wish to assist with washing, and they may have been caring for the person prior to death. When moving the deceased air can be released; this should not be mistaken for breathing. Further soiling may also occur.	Sensitively share this information with the key contact or carer assisting with the personal care. .
Dress the deceased appropriately before they go to the mortuary or funeral directors. This may be in a shroud or personal clothing depending on the place of death, local policy or wishes of the key contacts. Key contacts and/or carers may want to dress the deceased. As above, when moving the deceased, air can be released; this should not be mistaken for breathing. Further soiling may also occur. The deceased should never go to the mortuary naked or be released naked to a funeral director from an organisation without a mortuary on site. The Funeral Director may ask for a second set of clothes for the deceased to be buried/cremated in.	To ensure the deceased's dignity is always preserved Sensitively share this information with the key contact or carer dressing the deceased. To maintain their dignity and privacy.

ACTION	RATIONALE
Remove jewellery in the presence of another member of staff, unless specifically requested by the key contact to do otherwise, and document this according to local policy. Any jewellery removed must be placed in a valuable's property envelope and sealed in a clear plastic bag. Provide a signature if any jewellery is removed. Secure any rings left on with minimal tape, documented according to local policy. Be aware of spiritual/religious/cultural ornaments that need to remain with the deceased. Ensure these are clearly documented.	To meet legal requirements and key contact's wishes. Safekeeping of valuables. To reduce the risk of the ring(s) falling off. To respect the wishes of the deceased /key contact. Refer to their Advance Care Plan if in place.
Clearly identify the deceased with a name band on their wrist or ankle. As a minimum this needs to identify their name, date of birth, address, (and ward if a hospital in-patient) and ideally their NHS number. In the community setting, it is recognised that identification of the deceased is likely to be via a verification of death form. Do not use a toe tag.	To ensure correct identification of the deceased.
With a clean sheet placed under the deceased, wrap the body ensuring face and feet are covered and all limbs are	To protect the condition of the deceased and avoid damage during transfer of the deceased.

ACTION	RATIONALE
held securely in place. In community settings, the funeral director will do this. Use tape to secure the sheet in place. Do not bind the sheet or tape too tightly.	This can cause abrasions and/or disfigurement.
Complete documentation such as the 'notification of death' card and attach to the outside of the sheet of the deceased.	To ensure correct identification of the deceased.
If there is significant leakage, place the deceased into a body bag. A body bag may also be required for some infectious notifiable diseases.	To prevent risk of contamination to those handling the body from leakage of fluids.
If the body continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director.	To prevent risk of contamination to those handling the body from increased leakage of fluids.
Request transfer of the deceased: In hospital settings, it is best practice for porters to take the deceased to the mortuary within one hour of request, to be refrigerated within four hours of death. In community settings such as community hospitals, care homes and hospices, local arrangements should be made with the funeral director for collection of the deceased, ideally within 4 hours of death. In the deceased's own home, local arrangements can be made by the key contacts. Support, guidance, and	Prevents distress to surrounding patients, and (if requested) ensures tissue donation can take place. Optimum time for refrigeration of the deceased is 4-6 hours. To ensure arrangements are in place for the transfer of the deceased to the funeral director or equivalent.

ACTION	RATIONALE
signposting with this may be needed depending on the circumstances.	
Place any valuables in a Valuables property envelope. Provide a signature for any valuables. Ensure all property is packed with care and labelled with the deceased's details. In the clinical setting, list all property in the property book (or equivalent).	To ensure the safe keeping of all valuables. Ensures a record of all property is available when handing over to the key contacts.
Clean the area as soon as possible after the deceased has been transferred in line with the local Infection Control policy. Where a hospital bed or any other loaned equipment is in the home, follow local policy on advice for decontamination and return of the equipment.	To eliminate potential spread of infection
Document in the clinical notes that personal care after death has been carried out, and the property, including any valuables, has been listed, and the conversation with and advice given to the key contact(s) of the deceased.	To ensure a clear record of events is recorded.
Give opportunity for staff debrief. Be sensitive to own and others experience of caring for the deceased prior to dying	Allows for anxieties and concerns to be addressed at the time, giving recognition and validity to the feelings,

ACTION	RATIONALE
and/or at the time of death. Further support or reflection may be needed.	and may avert potential of unexplored emotions reaching crisis point.

Education and Training

Pre-registration training

59. We recognise that since the previous edition of care after death, education and training on all aspects of care after death are increasingly included on all relevant pre-registration training curriculum – particularly for medicine, nursing, and social care. Health and social care workers at every level should be able to access pre-registration training around the care and responsibilities in relation to a death, including spiritual, religious and cultural awareness, bereavement training and concepts of self-care⁷². It is expected that mortuary staff will be working towards or have completed the training by the Royal Society for Public Health (RSPH) - Level 3 Diploma in Healthcare Science (Anatomical Pathology Technology).

Induction and continued professional development

60. Commissioners should ensure that all staff, regardless of sector or employer, have access to appropriate training. The pertinent aspects of care after death for the relevant staff are:

STAFF GROUP	CARE AFTER DEATH TRAINING
<i>All staff</i>	Consider bereavement awareness training.
<i>Medical Practitioners</i>	Communication about breaking bad news and managing important conversations; verification of death; completion of MCCDs; appropriate referrals to the coroner and the Medical Examiner system (England & Wales) / Death Certification Review Service (Scotland). <i>It is noted that Organ and Tissue donation after death is governed by different laws in different UK countries and training must be country specific and cover the different</i>

	<i>consent provisions with regard to post-mortem examination and possible organ and tissue retention and organ and tissue donation</i>
<i>Nursing Staff</i>	Communication about breaking bad news and managing important conversations; verification of expected adult death; personal care after death including managing the deceased's property; coronial referrals and effect on viewing, documentation of care after death, safe disposal of controlled medicines and the Medical Examiner system / Death Certification Review Service (Scotland).
<i>Ambulance Clinicians</i>	Accessing electronic patient records that record people's wishes and preferences; communication about breaking bad news and managing important conversations; recognition of life extinct and supporting those present at the time of death; appropriate referrals to the police and coroner services and documentation of care.
<i>Porter Staff</i>	Safe handling and transferring of the deceased while maintaining their dignity and respect; sensitive communication with those present at the bedside.
<i>Care agency staff - Social Care, NHS or privately funded</i>	Training on personal care after death; communication and responsibilities if the deceased has no family or key contact; sensitive communication with the bereaved and documentation of care
<i>Domestic Staff</i>	Awareness training on the needs of the bereaved.
<i>Bereavement Support/Liaison Staff</i>	Sensitive communication with the bereaved and bereavement support offered to key contacts; process for collection of MCCDs; referral to the coroner and the Medical Examiner system / Death Certification Review Service (Scotland).
<i>APT Mortuary staff</i>	Management of the deceased; supporting viewings; communication with families, and systemic working with

	others in the care setting and the new Medical Examiner system.
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Individual and team debrief

61. The opportunity for debriefing should be available for staff after a death⁷³. In places of care where deaths happen frequently, e.g. acute hospital trusts, debriefing may take place after exceptionally challenging deaths or when the cumulative effect of many deaths is recognised. Some Trusts offer After Action Reviews (AAR)⁷⁴ with a facilitator to support this reflective learning in practice. Schwartz rounds are also routinely organised in many organisations to offer further space for collaborative reflection and support⁷⁵. Mortality and Morbidity meetings are another resource to support reflection and potential improvement in care especially when facilitated by a standardised mortality review process.

Organisational learning

62. All incidents related to care after death should be accounted for within the organisation for local action and governance with escalation, according to the seriousness and widespread applicability of any learning points or actions. Serious incidents and near miss incidents that take place in a mortuary setting must be reported to the Human Tissue Authority (HTA)⁷⁶.

NB: HTA does not have jurisdiction in Scotland. All staff working in the mortuary should be aware of the reporting requirements and this should be addressed in training.

63. NHS Trusts are now required to participate in 'Learning from Deaths' with the purpose of extrapolating the learning and disseminating this information across the trust⁷⁷. In a community setting it is also considered good practice to adopt a multi-disciplinary approach to learning from deaths.

64. Compliments and positive correspondence from key contacts are also used to support learning and improvements in providing quality care Trust wide. They are also a great source for providing a morale boost within the workforce.

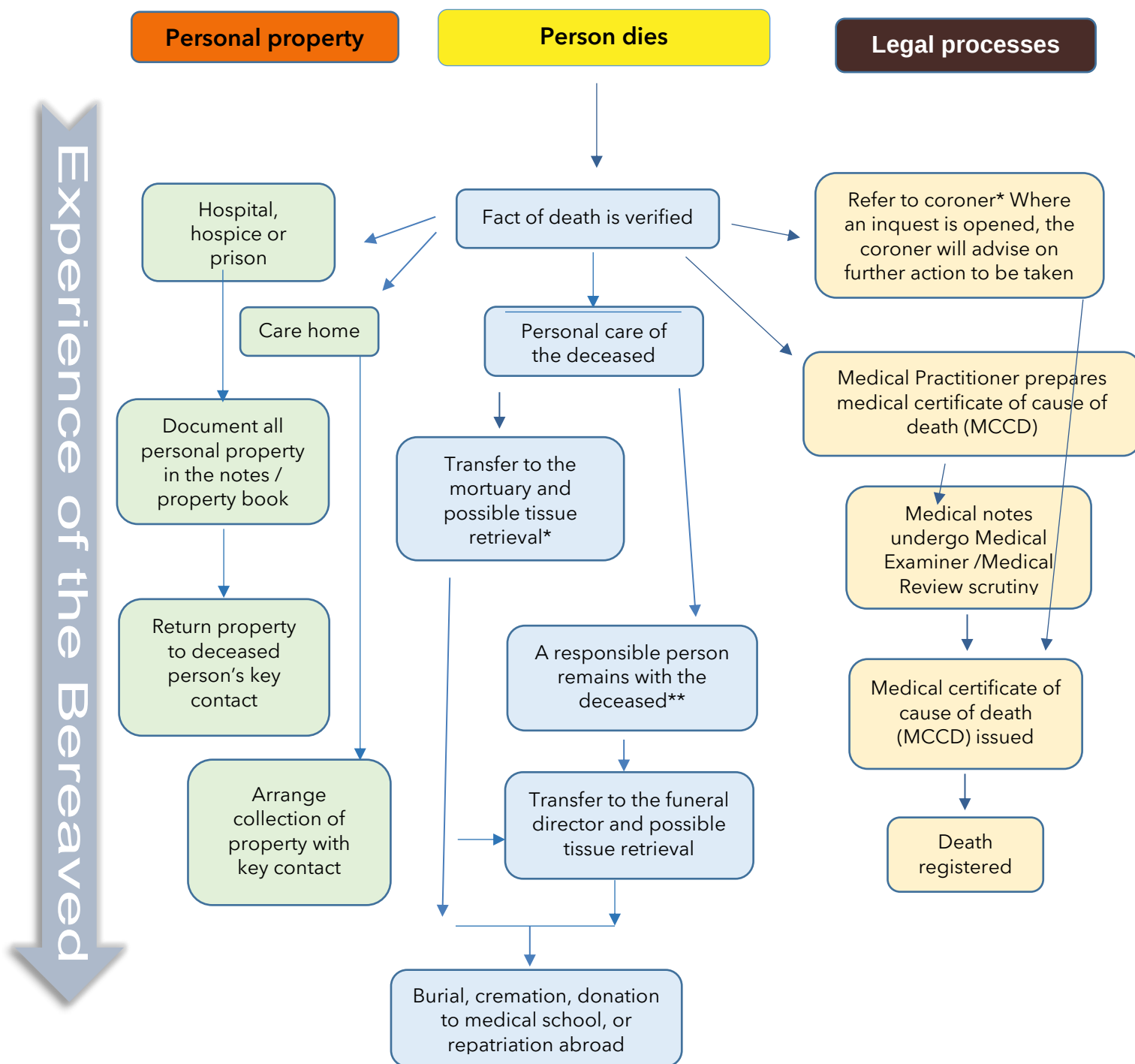
Further learning resources

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All links checked 22 October 2024.

Appendix 1

Processes of care for the deceased



This whole process should be set within the context of the deceased's spiritual, religious, and cultural wishes about care arrangements. Family members and carers should be given information and support.

* See Appendix 2 for further information on deaths requiring coroner investigation

** This may be a health or care provider where no other responsible person is available e.g. NOK

Appendix 2

Deaths requiring coroner investigation

Deaths requiring referral to the coroner in England, Northern Ireland or Wales, and the procurator fiscal in Scotland, for investigation are where the cause of death is unknown, sudden, suspicious, or unexplained; when the death: ^{78 79}

- may be caused by violence, trauma, or physical injury, whether intentional or otherwise
- may be caused by poisoning, drug related, including adverse drug reactions (reportable under the Medicines and Healthcare Products Regulatory Agency – MHRA)
- may be the result of misadventure, intentional self-harm, or possible suicide
- may be the result of neglect, including self-neglect, or failure of care
- may be related to a medical procedure or treatment, a failure of a piece of equipment, an operation or before recovering from the effects of an anaesthetic
- may be due to an injury, disease, or industrial poisoning in the course of employment
- occurred where the deceased was not treated by a doctor during their last illness, or a doctor did not see or treat them for the condition from which they died
- occurred while the deceased was in custody or state detention, whatever the cause.

Notification of infectious diseases

Notifiable diseases are nationally reported in order to detect possible outbreaks of disease and epidemics as rapidly as possible, and it is important to note: ⁸⁰

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infectious disease, and without waiting for laboratory confirmation, at time of diagnosis.
- All laboratories where diagnostic testing is carried out must notify their national Public Health authority of any confirmation of a notifiable infectious disease.

Appendix 3

Information required by mortuary staff and funeral directors

Local policies should ensure that the following information is generated from the place of death and provided to mortuary staff and funeral directors:

- Identifying information including name, date of birth, address and NHS number (if known)
- Date and time of death
- Name of the doctor referring to ME and managing the death process
- Implantable devices
- Current radioactive treatments
- Notifiable infections
- Any jewellery or spiritual/religious/cultural mementoes left on the deceased
- Name and signature of registered nurse responsible for the care after death
- Name and signature of any second healthcare professional who assisted with care

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