

Getting it right at the end

Caring for the dying and bereaved -
A Working Guide for NHS Staff

This document is also available in large print and other formats upon request. Please contact Rev Fred Coutts on (01224) 553316 for a copy.

Foreword

Caring for dying patients and their bereaved relatives, carers and friends is an important part of the work of many health professionals. In order to assist staff with this challenging part of their work Guidelines on the Care of the Dying and Bereaved have been revised.

Throughout NHS Grampian information is already available in different documents on various aspects of caring for patients and relatives before and after death. The current guidelines reflect good practices within NHS Grampian, drawn together into one working document.

You may not wish to read the whole document but to use the sections which are relevant to your practice. The guidelines are intended to be a practical help to all our staff, particularly to those who have had limited experience in this challenging field. Experienced staff may also find the document useful when they are teaching.

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Contents		Page
1.	Introduction	7
	Checklist Care for patients before death	9
2.	Care for patients before death	10
	2.1 Caring for dying patients	10
	2.2 Communicating with dying patients	10
	2.2.1 Private conversations	
	2.2.2 Help in breaking bad news	
	2.2.3 Telling the patient	
	2.2.4 Answering questions	
	2.2.5 Unresolved family conflicts	
	2.2.6 The language barrier	
	2.2.7 People with disabilities and additional needs	
	2.3 Religious and ethnic minorities	12
	2.4 Practical care	13
	2.4.1 Individual practical care	
	2.4.2 Control of symptoms	
	2.4.3 Allowing a patient to die	
	2.4.4 Team Working	
	2.5 Where to care for dying patients	14
	2.5.1 Where to care for dying patients when they are in hospital	
	2.5.2 Dying at home	
	2.6 Communication issues	15
	2.6.1 Communication among people caring for the patient	
	2.6.2 Knowing who to contact	
	2.7 Spiritual and religious care	16
	2.8 Staff with counselling skills	18
	Checklist Support for relatives of dying patients	20
3.	Support for relatives of dying patients	21
	3.1 Knowing the family	
	3.2 Welcoming relatives	

3.3	Talking and listening to relatives	
3.4	Organ and tissue donation	
3.5	The language barrier	
3.6	Communication among staff	
3.7	Facilities for visitors	
3.8	Caring together	
3.9	Children of dying patients	
Checklist	Care for patients and relatives at the moment of death	24
4.	Care for patients and their relatives in hospital at the moment of death	26
4.1	Calling relatives	
4.2	Sitting with dying patients	
4.3	Different responses to death	
Checklist	Care for relatives in hospital when a patient has just died	28
5.	When a patient has just died	29
5.1	Sitting by the patient	29
5.2	Communicating with relatives	29
	5.2.1 Breaking bad news	
	5.2.2 Talking to relatives in private	
	5.2.3 Discussing the death with a senior doctor or nurse	
	5.2.4 Bereaved children and parents	
	5.2.5 Explaining what will happen next	
	5.2.6 Communication difficulties	
	5.2.7 Primary health care team	
5.3	Other hospital departments	31
5.4	Releasing information	31
5.5	Support for the newly bereaved	32
	5.5.1 Supporting relatives	
	5.5.2 Social workers/care managers	
	5.5.3 Religious support	
	5.5.4 Spiritual support	
	5.5.5 Hospital chaplains	
	5.5.6 Scottish Episcopal, Church of England etc	
	5.5.7 Roman Catholic Church	
	5.5.8 Other faith groups	
	5.5.9 Leaving the hospital	
	5.5.10 Ongoing support	
5.6	Concern for other patients in the ward	36
	5.6.1 Telling other patients	
	5.6.2 Removing bodies from the ward	

5.7	Last Offices	37
5.8	Viewing the body	37
	5.8.1 Supporting relatives	
	5.8.2 Mortuary viewing area at Foresterhill	
	5.8.3 Mortuary at Woodend Hospital	
	5.8.4 Mortuaries at Elgin	
	5.8.5 Arrangements at other hospitals	
	5.8.6 Trauma and viewing	
5.9	Sudden or unexpected death	40
5.10	Sudden or unexpected death in the Accident and Emergency departments.	41
	5.10.1 Facilities	
	5.10.2 The role of the named nurse in supporting the relatives	
	5.10.3 Breaking bad news	
	5.10.4 Viewing the body	
	5.10.5 Patient's property	
	5.10.6 Information for relatives	
5.11	Sudden death in theatres or during medical procedures	44
5.12	Informed decision about organ and tissue donation	45
	5.12.1 The role of the transplant coordinator	
	5.12.2 When to offer organ/tissue donation	
	5.12.3 Brain Stem testing	
	5.12.4 Offering the option of organ/tissue donation	
	5.12.5 Authorisation	
	5.12.6 Talking to relatives	
	5.12.7 Follow up care	
5.13	When there is a stillbirth, neonatal death or the death of a baby of less than 24 weeks' gestation.	48
5.14	When a child dies.	50
	5.14.1 Combined Child Health	
	5.14.2 Sudden death of a child	
	5.14.3 Expected death of a child	
	5.14.4 Expected death of a child at home	
	5.14.5 Contents of Bereavement Pack	
6.	Support for staff.	57
Checklist	Administrative and other procedures after a death	58

7.	Administrative and other procedures after a death	60
7.1	Giving information to relatives	
7.2	Procedures for death in hospital and community	
7.3	Notification of death to general practitioners	
7.4	Procurator Fiscal cases	
7.5	Death certificate	
7.6	Post mortem examination required	
7.7	Cremation papers	
7.8	Bodies bequeathed to Anatomy, School of School of Medicine and Dentistry	
7.9	Patients' personal property	
8.	Useful telephone numbers.	69
Appendices		
Appendix 1	How to contact a social worker/care manager.	72
Appendix 2	How to contact a hospital chaplain.	74
Appendix 3	Interpretation in NHS Grampian	76
Appendix 4	How to contact the on-call anatomical pathology technician, Foresterhill site (mortuary technician)	78
Appendix 5	Death and the Procurator Fiscal (Crown Office Circular)	79
Appendix 6	Procedure for Last Offices for patients who die in the hospital setting	97
Appendix 7	Forms and paperwork commonly used when someone dies in hospital.	106
	Recommended reading	110
	Members of the working group	120
	Index	122

1 Introduction

This document seeks to describe good practice for the care of the dying and bereaved throughout NHS Grampian, building on the Aberdeen Royal Hospitals guidelines on Caring for the Dying and Bereaved published in 1998.

In 1990, a Working Group of the Scottish Health Service Advisory Council considered "The care of the dying and bereaved in Scotland". The group's report, published in 1991 was entitled ***Everybody's death should matter to somebody***. This report recognised the "wholeness of each person and therefore the uniqueness of each person's death". "The personal responsibility of caring for the dying" was seen to be carried out by a range of professional and lay carers each deserving acknowledgement and support. The needs of the bereaved were considered and it was noted that good care of the dying, by reducing undue suffering in bereavement, can lead to better health for the bereaved.

The following principles were established in the Report ***Everybody's death should matter to somebody***:

- 1. No one should die alone.*
- 2. Throughout the process of illness and ageing an individual's right of choice must be respected and retained.*
- 3. The place of dying should be such as to preserve dignity and privacy for the dying person and those with them.*
- 4. Professional people caring for the dying and the bereaved should share responsibility, recognising the limits and the strengths of their professional and personal resources and giving proper place and space to the closest companion to the dying person.*
- 5. Professional people caring for the dying and bereaved in whatever setting should have adequate education, preparation and support on a continuing basis.*

Throughout these guidelines the word *relatives* and *family* should be understood to include carers and close friends. It may be necessary for staff to identify one or more close relatives, carers and friends who take prime responsibility for the patient and who will communicate with other family members and friends.

Picture: Garden Sketch

Care for patients before death

Checklist:

1. If dying patients have few or no visitors when in hospital, do members of staff spend extra time with them? (2.1.2)
2. Do all members of staff know how to get help if they feel out of their depth when talking to dying patients? (2.2.2, 2.2.3, 2.2.7, 2.7, 2.8)
3. Do senior medical and nursing staff regularly offer dying patients the opportunity for private one-to-one conversations? (2.2.1)
4. Who is responsible for deciding whether or not to resuscitate or discontinue unnecessary or distressing intervention? Who is involved in this decision? Is it recorded? Are all staff aware of what has been decided? (2.4.3)
5. If patients are readmitted to hospital in the final stages of the illness are they normally admitted to a familiar ward? (2.5.1)
6. If dying patients wish to die at home or move to another hospital are staff able to organise relevant practical support and help? (2.5.2)
7. When a patient is in hospital, who is responsible for informing the general practitioner and, when relevant, the referring doctor about discharges or significant changes in the patient's condition? (2.5.2, 2.6.1, 2.6.2)
8. Do patients' nursing notes always contain clear and full information about how to contact appropriate relatives, the general practitioner and, when relevant, the referring doctor? (2.6.1, 2.6.2)
9. Do all ward staff know how to contact the hospital chaplains and local faith group leaders? Is particular attention paid to making spiritual and religious support available if this is appropriate? (2.7, Appendix 2)
10. Are staff aware, and do the patient notes contain appropriate information regarding any post mortem wishes regarding tissue donation, research or autopsy of the patient and/or family? (7.6)
11. Civil partnerships are something that all healthcare staff need to be aware of, especially when dealing with end of life issues. It is possible that a terminally ill patient may have entered into a civil partnership, of which their families are not aware.
12. Staff need to be aware how to access communications support (such as Language Line, face to face interpreters, portable induction loops, British Sign Language interpreters and specialist support for people with learning disabilities and aphasia), if required.

2. Care for patients before death

2.1 Caring for dying patients

2.1.1 Patient care

The aim of health service staff caring for patients who are dying, or who may die, is to ensure that each patient's death is handled as sensitively and helpfully as possible and that adequate support is offered to relatives before and after the death. This requires skill and sensitivity and can be emotionally very demanding and time consuming. Staff at all levels are likely to need support and training to carry out this part of their role successfully.

2.1.2 Giving time to dying patients

Medical, nursing and other staff who find death and dying difficult to deal with may avoid dying patients and their relatives`. At the same time those who are dying may be extremely sensitive to the way other people behave towards them and are likely to be in special need of human contact, comfort and reassurance.



Dying patients are as important and need at least as much practical and emotional care as patients who will survive.

This must be taken into account when planning their care, even though it may be particularly difficult in a busy working environment. In hospitals, if dying patients have few or no visitors a named nurse should make a special effort to spend time with them or arrange for someone else to do so.

2.2 Communicating with dying patients

2.2.1 Private conversations

One-to-one

Most patients find it difficult to ask important questions about their prognosis or to discuss their worries and feelings in public or in front of a group of staff. All patients should be offered regular opportunities for private one-to-one time with senior doctors and nurses.

2.2.2 Help in breaking the bad news

When bad news must be given to a patient staff should consider how, when and with whom this information should be given. It may be helpful to be accompanied by an experienced member of nursing staff, known to the patient. A Macmillan nurse, social worker/care manager or chaplain could also be called to the interview. Together they may be better able to help the patient to understand the diagnosis and reduce their anxieties. They can also discuss immediate and long-term questions and worries. Opportunities for on-going support should be arranged.

2.2.3 "Telling" the patient

How much to tell?

Although most patients wish to know their prognosis, some do not. It is important to let each person decide what they want to know and when, and to answer any questions as honestly as possible. Patients are the best judge of how much knowledge they can handle at any time although this may be conveyed in subtle ways. If worried relatives ask medical and nursing staff not to tell a patient the truth, staff must remember that their first responsibility is to the patient and to answer honestly any question they may choose to ask. It is important to explain this to relatives and, if possible, to encourage them to speak openly with the patient.

If both members of the partnership are told together, communication about the whole illness and the future is made a little easier. Artificial barriers can prevent the partners helping each other. This may mean that a patient dies without the partners being able to discuss the issue together, to say all the important things they might have wished to say to each other. The result is a much more serious level of bereavement for the survivor.

Staff may find it particularly difficult when the dying patient is a child, or the child is the carer. Support and advice for staff who have to break the bad news may be available from social workers/care managers, general practitioners, hospital chaplains or other family members.

It is important to explain clearly to healthcare staff, including primary care staff who will be in contact with the patient, what has been discussed.

2.2.4 Answering questions

Patients may ask any member of staff or students at any time about their condition and wish to discuss their feelings, hopes and worries. All nurses and doctors however junior (including students) and other staff who provide care for patients should have up-to-date, though not necessarily specialist, knowledge about a patient's condition. They should feel able to give time to patients when they wish to talk and should know how to get help if they feel out of their depth. Staff should be advised how to deal with patients' questions, including, where appropriate, calling a senior member of staff to talk to a patient. Any member of staff with whom a dying patient has developed a close relationship should be recognised as an important person in the care of that patient.

Practical questions

Staff should grasp opportunities to talk to dying patients about practical matters, such as the making of wills (social workers/care managers will be able to help in this matter), family reconciliations etc.

If the patient is to be discharged home or to a community hospital it is important to explain clearly to primary care staff what has been discussed with the patient.

2.2.5 Unresolved family conflicts

Staff should be aware of difficult situations which may arise because of unresolved family conflicts. These may be difficult to handle in an acute medical situation. Staff should try to find out the views of the patient on these matters and deal as sensitively as possible with such situations.

2.2.6 The language barrier

If a patient, their relatives and friends are non-English speaking, staff have the option of using either the Language Line telephone interpretation service or a face to face interpreter. However, if bad news is being communicated to a non-English speaking patient, a “face to face” interpreter should always be the first choice.

In some cases a member of the patient's family who speaks good English will be able to stay with the patient and act as interpreter. Arrangements in different parts of Grampian vary, but an official interpreter may still be needed for medical legal reasons. Doctors or nurses may wish to speak privately to the patient and discuss any problems that the patient does not feel able to discuss through a member of the family. There may also be times when communication is needed and the family member is not there to interpret.



Information about Language Line and how to contact an interpreter is contained in Appendix 3.

2.2.7 People with disabilities and additional needs

Staff may feel embarrassed or uncertain when caring for patients or relatives with physical or learning disabilities or psychiatric conditions and particularly for people with limited speech and/or apparently limited understanding. It is important to recognise that people with limited speech may have total understanding or understand a good deal more than their speech, tone of voice and posture indicate and that they are often particularly sensitive to another person's tone of voice and non-verbal signals. Whenever possible, relatives should be asked how best to communicate with such groups of patients. It is crucial that disabled patients and relatives are given the same respect and sensitive care as other people. Information about relevant documents can be found in the *Recommended reading* section on page 110.



For patients, relatives and friends who use a hearing aid, NHS Grampian has over 200 portable induction loops (PILs) in use in wards and departments. PILs can be obtained by contacting the Equality and Diversity Assistant on extension 51116 (direct dial 01224 551116) or by email (roda.bird@nhs.net). For profoundly deaf people, British Sign Language (BSL) interpreters can be accessed through the Administration Department at ARI (extension 53674, or email michelle.harrows@nhs.net).

In addition DeafBlind Communicators can also be sourced, if required (contact telephone number DeafBlind Scotland 0141 777 6111, 0141 775 3311 or email info@deafblindscotland.org.uk).

2.2.8 Patients with learning disabilities or aphasia

Patients with a learning disability, aphasia or a range of certain illnesses or conditions may require additional communication support to understand the information being provided. Staff can help by saying one thing at a time, giving the person time to take in the information and to respond. It can often help to write down choices and encourage patients to point or draw. Staff should recap regularly and check that the patient has understood the information being conveyed. More specialised support can be provided by Speech and Language Therapists.

2.3 Religious and ethnic considerations

Behaviour at a time of serious illness varies between cultures. It is important to ensure that all patients and families of whatever ethnic group receive the practical and emotional care they need. Recent documents such as ***Fair for All*** and the NHS Grampian ***Spiritual Care Policy*** refer to this. Cultural attitudes towards different patterns of family involvement, physical care, modesty and so on must all be taken into account. In a hospital setting it may be important for some patients that the whole family visits together. All staff should have training in these issues and should be encouraged to ask patients from ethnic minorities and their families about their needs and preferences. Food that is both appetising and acceptable to a particular religious group may have to be provided.



Helpful information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian). The text of this booklet is also available on the NHS Grampian Intranet. Further information and advice is available from hospital chaplains.

2.4 Practical care

2.4.1 Individual practical care

Stop unnecessary interventions

Practical care for each patient should be based on their individual needs. In hospital, medical or nursing interventions, for example daily temperature taking, blood pressure measurement, blood tests or X-rays should be reviewed and those not benefiting the patient should be discontinued with suitable explanation to the patient and relatives if appropriate.

2.4.2 Control of symptoms

Pain

Once an illness has been recognised as incurable the whole emphasis will change. There is a danger that staff at this stage, may say that “there is nothing further to be done” and that a feeling of failure and/or guilt may cause them to distance themselves from the patient. Nothing could be less appropriate. Treatment changes direction and may indeed become more intense. When pain is present, the skilled use of analgesics and other techniques is essential.

Other symptoms

Other symptoms may be as important or more important, for example, breathlessness, nausea, anorexia, local oedema or abdominal distension by ascites. Staff must reassure their patients that they are concerned about all their complaints and that they will do whatever they can to help with each. Showing genuine interest and making honest attempts to help will play a crucial role in maintaining trust to the end.



Specialist help may well be required, for example from the specialist palliative care services for Grampian based at Roxburghe House. A 24 hour telephone advice service for healthcare professionals is available (01224 557057). For patients in Aberdeen Hospitals the hospital specialist palliative care team is available during office hours (ext 54001 or fax 54002). At Dr Gray's Hospital the Hospital Palliative Care Team can be contacted on 01343 567480. Patients or carers in the community setting should contact their out-of-ours service.

The community Macmillan nurse specialists can provide advice and support for patients and healthcare professions in the community setting, including community hospitals. (See Section 8 for contact telephone numbers)



The local **palliative care guidelines** are available on the NHS Grampian Intranet.

2.4.3 Allowing a patient to die

The decision to allow a patient to die is often very difficult. However, much distress can be caused to dying patients, to their relatives and to staff if efforts are made to resuscitate them when their quality of remaining life will clearly be poor. In taking decisions about resuscitation, doctors should always take into account the views of the patient, relatives and carers when these are known. The views of the patient at all stages of an illness must always be given fullest consideration. The decision "Do not Resuscitate" must be recorded in both the medical and nursing notes and medical staff record clearly in the notes that the patient is dying, that medical attention has switched to palliative care and the care plan for the future.



All staff should be aware of what has been decided with regard to particular patients.



Staff should be familiar with the NHS Grampian **Not for Resuscitation Policy** and the NHS Grampian **Advance Directives (Living Wills) Policy**.

2.4.4 Team working

Effective communication should be encouraged between all staff caring for patients in hospital and community to allow for continuity of care.

2.5 Where to care for dying patients

2.5.1 Where to care for dying patients when they are in hospital

What does the patient want?

The decision about where best to care for a patient dying in hospital depends largely on their own wishes and needs, and on the facilities available in the ward. Some patients may wish for peace and quiet and thus prefer to be moved to a side room, although it is important to ensure that patients in side rooms do not become isolated. Others may prefer to be part of life in the ward. Some patients may like to be moved closer to the office or staff desk. Strategies must be developed at ward level to provide the best option for patients and their families.

Patients who go home for a while but return to hospital in the final stages of their illness should normally be admitted to a familiar ward.

2.5.2 Dying at home

Many patients do not go into hospital at all but die at home in the care of integrated health and social care teams who provide practical help and reassurance

Some patients in hospital may wish to die at home. Staff must discuss this with patients and carers at an early stage. If the patient wishes to return home to die, this should be organised as speedily as possible, provided relatives feel they can cope and appropriate support is available. Social workers/care managers are experienced in arranging appropriate care and liaising with community based health professions to enable speedy discharges when the need arises.



If a patient is going home from hospital, the liaison nursing service will coordinate the discharge and will discuss this with the integrated health and social care teams within general practices before discharge. They can then organise support services, including Marie Curie; contact carers at home; reactivate or further develop relationships; organise equipment, services and appropriate transport without unnecessary delay especially where no active treatment is to be offered.

Practical help and reassurance will be needed by the carers and can be provided by the integrated health and social care teams which includes a designated community Macmillan nurse specialist. Some patients may wish to spend their last days or weeks nearer home in a local hospital. Staff should help to organise this whenever possible as well as offering short stays in hospital for respite care to support carers.

2.6 Communication issues

2.6.1 Communication among people caring for the patient

Good two-way communication between primary and secondary care is essential to keep patients and their relatives well informed. This is particularly important when dying patients are being transferred between care settings. Liaison nurses play an important role in maintaining good links between hospital and community nurses.

2.6.2 Knowing whom to contact

To enable fast and efficient communication, each patient's nursing record must contain clear and fully up to date information about how to contact appropriate relatives, the patient's general practitioner and, when relevant, the referring doctor. In hospital it is particularly important that staff know where to find this information, for example, when a seriously ill patient is moved to theatre or the Intensive Therapy Unit or between wards. It is also important any post mortem wishes are documented, ie corneal donation or specific tissue bequests.

2.7 Spiritual and religious care

2.7.1 Spiritual care

Appropriate spiritual support should be offered to **all** patients, their relatives and carers. This care should be available to people with or without specified religious beliefs. Everyone, whether religious or not needs support systems, especially in times of crisis. Many patients and carers, especially those confronting serious or life threatening illness have spiritual needs and welcome spiritual care. They face ultimate questions about life and death. They search for meaning in the experience of illness. They may look for help to cope with their illness and with suffering, loss, loneliness, anxiety, impairment, despair, anger and guilt. They may address in depth, perhaps for the first time, the realities of their human condition. Those who express their spirituality through a religious framework have the right to have their religious needs met. Spiritual care, however, is not necessarily religious and is usually given in a one-to-one relationship, being completely person-centred. Staff should be aware of these spiritual needs and offer appropriate care as part of a truly holistic approach, seeking help from hospital chaplains as necessary.



More information about spiritual support can be found in the ***NHS Grampian Spiritual Care Policy***.

2.7.2 Religious care

Staff must ensure that patients, when they request it, receive appropriate religious support from a chaplain, religious leader or faith community member. In hospital, ward staff must record whether patients wish to be visited by a hospital chaplain, a local minister, priest or religious leader, or by someone they already know and pass this information on to the appropriate people. Hospital chaplains can assist in identifying and contacting faith communities and churches.

2.7.3 Hospital Chaplains



There are hospital chaplains appointed to every hospital in Grampian. As part of the multidisciplinary team, they have a specialist role in the delivery of spiritual, pastoral and religious care. Chaplains are available to come to see patients, their relatives and carers at any time. In Aberdeen a 24 hour on-call service for chaplaincy call-outs is in operation. Chaplains are available to people with or without specified religious beliefs and will offer spiritual or religious care themselves or find the appropriate support from the patient's faith community.

Information on how to contact hospital chaplains is included in Appendix 2.

2.7.4 Faith groups

Christian churches

Hospital Chaplains can assist in contacting local churches where patients belong to a local faith community: eg Church of Scotland, Roman Catholic, Baptist, Episcopal etc. They can also offer direct support to such patients themselves.

Information on how to contact a hospital chaplain is included in Appendix 2.

Scottish Episcopal Church, Church of England and other Churches of the Anglican Communion

In hospital, a dying patient who is a member of the Anglican Communion (this includes the Scottish Episcopal Church, the Church of England, the Church in Wales and the Church of Ireland) would normally wish to see the chaplain for the Scottish Episcopal Church or their own priest. Prayers may be said and patients, who wish, may be anointed with oil and receive Holy Communion. If there is a serious deterioration in the patient's condition, ward staff are asked immediately to contact the Episcopal Church chaplain or the patient's priest - day or night.

Information on how to contact the Scottish Episcopal Church chaplain is included in Appendix 2.

Roman Catholic patients

A patient who belongs to the Roman Catholic Church would normally wish to see a priest and to receive the "Sacrament of the Sick" (Confession, Anointing and Holy Communion). If there is a serious deterioration in the patient's condition, ward staff are asked immediately to contact the Roman Catholic chaplain or the patient's priest - day or night.

Information on how to contact the Roman Catholic chaplain is contained in Appendix 2.

Other faith groups

Information about other faith groups (Muslim, Buddhist, Jewish etc) and how they may be contacted can be obtained from hospital chaplains who will help facilitate appropriate support for patients, their families and carers.



The booklet ***Religions and Cultures in Grampian***, (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian) is available from the Chaplains' Offices at Aberdeen Royal Infirmary and Royal Cornhill Hospital. The text can also be found on the NHS Grampian Intranet.

2.8 Staff with counselling skills

In special cases, when staff are unable to meet the needs of patients or relatives who are particularly distressed, they should be able to call on staff with counselling skills (such as a social worker/care manager, a Macmillan nurse, or chaplain etc).

Picture: Sketch 2 of Verrochio hands

Support for relatives of dying patients

Checklist:

1. In hospital, is a key member of staff identified to get to know the relatives well and to keep them informed? (3.1, 3.3, 5.8.1, 5.9, 5.10.2)
2. Are relatives given unrestricted access to the patients when in hospital, including through the night? (3.7)
3. Are opportunities provided for relatives to help with the day-to-day care of the patient? Is their potential contribution recognised and valued by staff? (3.2, 3.8)
4. Do senior members of medical and nursing staff offer relatives time to ask questions and discuss their worries in private? (3.3, 5.9)
5. How do staff record and communicate what has been said to relatives and what worries or requests they have expressed? (3.6)
6. Do staff know when it is appropriate to raise the question of organ and tissue donation and how to access information? (3.4, 5.12)
7. Is special support and care provided for relatives of dying patients? What facilities are made available in hospital for relatives spending time with the dying patient? (3.7, 5.10.2)
8. What provision is made on the ward for the young children of a dying patient? Are their needs recognised? (3.9)
9. Do staff know where to get help to overcome language and communication barriers with the relatives of dying patients?

3. Support for relatives of dying patients

Throughout this document the word *relatives* and *family* should be understood to include carers and close friends.

Care for the patient includes support for the carers and family of which he or she is part. Appropriate support for relatives before, at and immediately after a death can help with the grieving process.

3.1 Knowing the family

Named nurse

Staff should take responsibility for discovering what family exists, how the patient and family wish to be involved and what special needs they have. This should preferably begin at the time of first contact. It may be useful to identify one key member of staff, usually a nurse, to get to know the relatives well and to have a special responsibility for keeping them informed and making sure that they receive the care they need.

All relevant staff should be briefed about the family and their support should be considered a vital part of the care provided.

Difficult situations may arise because of unresolved family conflicts. These can be difficult to handle in an acute medical situation and staff should seek to deal with them as sensitively as possible.

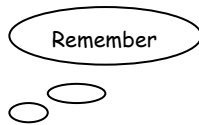
3.2 Welcoming relatives

Involve relatives

Many relatives have been caring devotedly for patients for some time. Their care and involvement and their continuing importance in the care of the patient must be acknowledged by staff. If the patient is admitted to hospital the family should be given every opportunity to continue to help with the day-to-day practical care of the patient but staff should acknowledge that they may also need to take a break. The welcome given to relatives and their involvement in the care of patients are among the most appreciated features which have been learned from the hospice movement. Staff can also often learn much from the care that relatives give to dying patients.

3.3 Talking and listening to relatives

Relatives need information as well as opportunities to ask questions and express their feelings. Every effort should be made to help relatives to get reliable information and to find out what is happening. With the patient's permission, senior medical and nursing staff should try to talk to the patient and close relatives together. This will avoid the problem that may arise when patients and relatives are given significantly different information. Staff should also offer visiting relatives time to discuss their worries and ask questions in private. Relatives should be encouraged to contact staff whenever they feel the need.



Relatives should be kept informed of developments in the patient's condition as they occur and particularly when death seems imminent.

3.4 Organ and tissue donation

The question of organ and tissue donation may be raised at this time. Staff should make themselves familiar with the information printed at 5.12.

3.5 The language barrier

If the relatives speak little or no English you should use Language Line if you have this available. In some circumstances an interpreter will be needed to make sure that relatives understand the situation, can ask questions and discuss worries. For non-English speaking relatives, face-to-face interpreters are recommended. If a face-to-face interpreter is not available, a conference call unit can be provided to facilitate a group discussion using the Language Line interpretation service.



Information about Language Line and how to contact an interpreter is contained in Appendix 3.

3.6 Communication among staff

When caring for patients, good communication among staff is essential to support the family. Important pieces of personal or family information should be shared to ensure that the best support possible is provided for the family. Staff must ensure that information about patients' or relatives' worries and requests are recorded in the nursing notes.

3.7 Facilities for visitors

As death gets closer it is important that patients should have unrestricted access to the relatives and friends they wish to see. A family member or close friend may wish to sit with the patient as death approaches. Staff should monitor the situation, however, to ensure that the patients and relatives get adequate rest.

*Comfort
and
privacy*

Relatives who visit frequently or stay with dying patients will need special support and facilities. These include comfortable chairs by the bedside, help in obtaining meals and refreshments, and an area in which to relax and talk privately. Some hospitals may be able to provide a room in which to stay.

Hospitals keep an accommodation list of nearby Bed and Breakfast establishments. In Aberdeen Bed and Breakfast for relatives is available at Red Cross House in Claremont Place. Contact information is in Section 8. Information about Bed and Breakfast accommodation is on the NHS Grampian website (www.nhsgrampian.org).

Bed and Breakfast accommodation is also available at **Clan Haven** for anyone affected by cancer who lives in the outlying areas of the North-East, Orkney and Shetland and who is accompanying a friend/relative to Aberdeen.



Information on how to contact **Clan Haven** can be found in Section 8.

3.8 Caring together

During the precious last days of a dying patient's life, staff should endeavour to be as supportive and flexible as possible in response to the patient's and relatives' needs and wishes. For example, if relatives, with the consent of the patient, wish to stay with a patient while nursing and other procedures are carried out they should be allowed to do so. If they wish they should be allowed to help.

3.9 Children of dying patients

Support is essential

It is most important that children should maintain contact with their dying parent. Provided the patient and the family agree, the young children of a dying patient should be allowed to spend time with their parent. If possible a side room should be provided to allow them to take time-out. Support needs to be given to both children and adults, acknowledging that members of the family may find it difficult in their own grief to give children the comfort they need. Depending on individual circumstances, however, it may be helpful to allow a child to see the body of a parent after death. This can help the child to accept the reality of the death and remember the parent restful and at peace rather than ill and suffering.

Support can be provided by a social worker/care manager, the general practitioner, the child's school or by other family members.

Linus Quilts



For many years quilts and blankets have been gifted to children in Royal Aberdeen Children's Hospital and the Raeden Centre, from Project Linus. More recently they have been offered to children facing the death of a sibling, parent or relative in the Intensive Therapy Unit and elsewhere in Aberdeen Royal Infirmary and Roxburghe House. These comforters, which the child keeps and takes home, can be offered by any member of staff. They are available for the hospitals in Aberdeen from the Chaplain's Office at Royal Aberdeen Children's Hospital (tel 01224 554905) or out of hours from ITU at Aberdeen Royal Infirmary.

Care for patients and their relatives in hospital at the moment of death

Checklist:

1. What is the procedure for calling close relatives to the bedside of a patient when death seems imminent? (4.1)
2. How do staff record and communicate the patient's and relatives' wishes about being called? (4.1, 5.2.1)
3. Are relatives encouraged to touch and talk quietly to dying patients even if they appear unresponsive? (4.2)
4. If no relative or friend is present does a member of staff stay with the patient when death is close? (4.2)
5. What is the procedure for contacting relatives if they are not present at the time of death and is it recorded in the nursing notes? (4.1, 5.2.1)
6. What is the procedure for informing other departments and agencies about the death of a patient. (5.2.7, 5.3)
7. Has the Religions and Cultures guidance been accessed with regard to religion, cultural or faith requirements?

Insert Picture: Single Lily B&W

4. Care for patients and their relatives in hospital at the moment of death

Throughout this document the word *relatives* and *family* should be understood to include carers and close friends

4.1 Calling relatives

Relatives often wish to be with a patient at the moment of death, even at night, and are distressed if they have not been called.



Nursing staff should discuss with relatives whether they wish to be called during the night if death seems imminent and who should be called.

This should be recorded clearly in the patient's nursing notes. Using the telephone to call relatives to the bedside of a dying patient or inform them of a death can be extremely difficult. Staff should also take the opportunity to prepare relatives for the fact that, even with the best of intentions, they may not be able to be present at the moment of death of the patient.

4.2 Sitting with dying patients

If no relative or friend is present when death is imminent, a member of staff should hold the patient's hand, even if the patient appears to be unconscious.



It is important to remember that patients who seem to be unconscious can often hear what is being said.

Relatives may find it comforting to be encouraged to talk quietly to a dying patient even if he or she seems to be unconscious. Nothing should be said in the presence of a dying patient that the speaker would not wish the patient to hear.

While endorsing the principle that no one should die alone, there may be circumstances when the patient has made a specific request to die alone. This wish should be respected.

4.3 Different responses to death

Personal and cultural factors

Cultural patterns and values become particularly significant when someone dies. For example, members of some ethnic groups mourn quietly and privately, others more overtly. Members of different religious groups will naturally wish to follow their own religious practices. Different responses may cause problems and resentment unless staff are both well informed and sensitive to the importance of allowing and encouraging dying patients and their relatives to grieve and react in their own way. In some cases it may be necessary to move a patient into a side ward to avoid disturbing other patients.



Helpful information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian). The text of this booklet is also available on the NHS Grampian Intranet. Further information and advice is available from hospital chaplains.

Care for relatives in hospital when a patient has just died

Checklist:

1. What is the procedure for contacting relatives if they are not present at the time of death and is it recorded in the nursing notes? (5.2.1, 5.10.3)
2. How do hospital staff prepare the body for the relatives to view? (5.7, 5.8.1, 5.10.4)
3. Are relatives encouraged to sit for as long as they wish with a patient who has just died? (5.8.1, 5.10.4)
4. Is there a quiet place where relatives can talk undisturbed and be offered a cup of tea? (5.2.2, 5.10.1, 5.10.2, 5.10.4)
5. Do staff make time to talk with newly bereaved relatives and allow them time to express their emotions? (5.2.2, 5.5.1, 5.10.2)
6. Are relatives offered the opportunity to speak in private to a senior doctor or nurse about the death and the circumstances surrounding it? (5.2.3, 5.9, 5.10.6)
7. How do staff provide support for relatives of patients who die suddenly? Do staff know how to mobilise special support for the relatives in such situations? Do staff give relatives the NHS Grampian Bereavement Folder? (5.5.2, 5.5.5, 5.9, 5.10, 5.11)
8. Do staff know when it is appropriate to raise the question of organ and tissue donation and how to access information? (3.4, 5.12)
9. Do staff know how to get additional support for newly bereaved relatives? (such as social work, and chaplaincy) (5.5.2, 5.5.3, 5.5.4, 5.5.5, 5.5.6, 5.5.7, 5.5.8 Appendix 1, Appendix 2)
10. Do all staff understand the administrative procedures following death and how to explain them to relatives? (5.2.5, 5.10.6, 7.1)
11. Do staff accompany relatives to the hospital door when they leave the ward? What arrangements are made for relatives who are alone, or for those returning to an empty house? (5.5.9, 5.5.10, 5.10.6)
12. Are relatives offered the opportunity to view the patient's body in the Mortuary viewing area? Who accompanies them? What support is offered to help them cope with this? (5.8.1, 5.8.2, 5.8.3, 5.8.4, 6.8.5, 5.8.6)
13. Who informs other patients in a ward when a patient has died? How is this done? (5.6.1)
14. Are religious, cultural or faith requirements taken into consideration? (5.5)

5. When a patient has just died

Throughout this document the word *relatives* and *family* should be understood to include carers and close friends.

5.1 Sitting by the patient

*Presenting
the body*

If the death has taken place in hospital, relatives should be encouraged to sit with a patient who has just died for as long as they wish. Curtains should be drawn around the bed for privacy. The face of a dead patient should not be covered while he or she remains in bed on the ward. Covering the face can be distressing for relatives who may arrive to see the body and can make death unnecessarily frightening and mysterious. If false teeth have been removed, they should be replaced as soon as possible. Relatives may also wish spectacles to be left on. The last offices should normally be left until relatives have left the ward unless relatives have made a specific request to be involved or particular religious or cultural issues arise.

5.2 Communicating with relatives

All hospital staff should make every effort to communicate effectively with relatives when a patient dies.

5.2.1 Breaking bad news

If relatives are not present when a patient dies, consideration should be given as to the most appropriate method of passing on this information, and who will do it. In most cases the bad news will be given by the senior nurse or doctor on duty. If death is anticipated, appropriate arrangements should be made in advance and recorded in the nursing notes.

Telephone:

This is often very difficult. It must be done sensitively but there are no fixed rules. It is essential to:

- Keep your voice calm.
- Introduce yourself and the hospital from which you are telephoning.
- Establish the identity of the person to whom you are speaking.
- Establish if the person is alone.
- Be honest with the relative and advise them that the patient has died. (such as "I am sorry to have to give you very sad news." followed by a pause may produce a response, "Oh, he/she has died.")
- Provide sufficient information clearly and briefly whilst allowing the relative time to absorb the news.
- Express your sympathy for them.
- If the person is alone, offer to contact someone else on their behalf (such as a friend, relative, neighbour etc) to provide support.



Police:

If you are unable to contact the next of kin, and you have exhausted all other options, telephone the police asking that they request the relatives to contact the ward immediately. Request the police to confirm whether or not they have been successful in contacting the relative.

- Non-emergency Grampian Police number: 0845 600-5-700

5.2.2 Talking to relatives in private



Bereaved relatives need time to themselves in an unhurried atmosphere. When relatives are ready, the nurse or the doctor who knew and looked after the patient should take them to a quiet area. They should be left to sit or talk as they wish and a cup of tea may be helpful.

Relatives must not be left to sit in public areas in the wards or corridors. They should be told about hospital chapels, sanctuaries or quiet rooms if these are available, as quiet places they may wish to use.



The services of a hospital chaplain or social worker/care manager may be offered (information on how to contact a chaplain or social worker/care manager is contained in Appendices 1 and 2)

5.2.3 Discussing the death with a senior doctor or nurse

*Review
appointment*

Relatives must be offered the opportunity to speak in private about the death and the circumstances surrounding it to a doctor or nurse who knew the patient - both immediately after the death and later. If relatives ask, an appointment should be made for them to see the senior doctor involved. Please note, however, that patients may request that their medical records are not made available to their relatives after death.

5.2.4 Bereaved children and parents

In certain cases, for example when children or adolescents lose a parent, or when parents lose a child, it may be particularly important to ensure that the family receives special support. Hospital staff should, as a matter of routine, make enquiries about the welfare of immediate family members, including children, find what help, if any, they are getting and, when necessary, refer the family to a suitable source of support, for example, from a social worker/care manager, the general practitioner, the child's school or other family members etc.

5.2.5 Explaining what will happen next

Hospital staff should explain briefly to relatives before they leave the ward what they will need to do regarding death certificates, registering the death, contacting funeral directors and making funeral arrangements etc. They should give appropriate literature (eg the NHS Grampian Information folder which contains the booklet ***What to do after a death in Scotland******practical advice for times of bereavement*** (Published by the Scottish



Executive Justice Department, the Death Certificate (if it is available at that time), The NHS Grampian booklet *Help for You Following a Bereavement* and any other local literature.)

5.2.6 Communication difficulties

Special care must be taken if language or disability creates difficulty in communication. If the relatives speak little or no English you should use Language Line if you have this available, or an interpreter. If relatives use British Sign Language, an interpreter must be found. Relatives coping with a death in unfamiliar surroundings and in a society they do not understand may need much help and support (see Appendix 3).

5.2.7 Primary healthcare team

Tell the GP

Hospital staff should telephone the patient's general practitioner as soon as reasonably possible, giving essential details and information. It is good practice for general practitioners to visit bereaved relatives as soon as possible after a death. The integrated health and social care teams within General Practices will provide support for relatives at home.

It is also helpful for a member of the ward medical staff to telephone the general practitioner to discuss the clinical details.

5.3 Other hospital departments

Referring doctors in the hospital and elsewhere should be informed quickly of the patient's death.

Local arrangements (such as Last Offices Policy) should be followed to inform the health records department etc in order that outpatient appointments etc be cancelled. Distress can be caused to family if appointment letters are sent to patients who have died.

5.4 Releasing information

5.4.1 Callers



Hospital staff should not give out information about the death of a patient to callers or visitors until the next of kin has been informed.

When the next of kin has been informed of the death, it is important to explain that there may be callers inquiring about the condition of the patient. It is essential that hospital staff confirm what response is to be given when "concerned" others telephone to make enquiries.

Some of the options are:

- Inform the caller that the patient has died.
- Advise the caller to contact the next of kin.
- Any other arrangement chosen by the next of kin.

The next of kin may welcome the offer of hospital staff informing others. However permission must be obtained before doing so.

5.4.2 Media

It may be that the circumstances which have brought a patient to a ward, or to the attention of a community health team, will attract media interest (such as a road traffic accident). This attention at times of distress may often be unwanted and disruptive to daily routine. The Corporate Communications team of NHS Grampian work with the media on a daily basis and their advice and services are available 24 hours a day.



Staff can contact the team on the following numbers - office hours (01224) 554400 or outwith office hours on pager number 07623 844473 and leave a message including your name and contact number. Corporate Communications will endeavour to return your call at the earliest opportunity.

The services of the Corporate Communications Department may also be offered to families who find themselves the subject of media interest after the death of a relative.

5.5 Support for the newly bereaved

5.5.1 Supporting relatives

Hospital staff have a continuing responsibility to provide support for newly bereaved relatives, not just to consider their task ended when the patient has died. By allowing relatives time with the patient, time to talk with staff in private and time to express their emotions, the initiation of the grieving process can be facilitated, and the risk of abnormal grief reaction in the future minimised. General practitioners, district nurses and community Macmillan nurses will provide support for relatives at home.

Staff need to find the appropriate and sensitive words to offer comfort and support. The use of touch can be tremendously helpful in showing those who are grieving that staff really do care and understand their distress.

Staff are not exempt from feeling emotions at times of death and should not feel it is wrong to show them.

Relatives may display anger and/or aggression following the death. Staff should be aware of this possibility and should not be reluctant to seek support in such a situation from a more experienced member of staff.

Difficult emotions

5.5.2 Social workers/care managers

Social workers/care managers are part of the team providing the necessary support and help which enables relatives to come to terms with the loss. It may be that the staff will identify particular difficulties encountered by relatives. These may be of a practical nature: eg benefits, finance, travel arrangements or care of children. They may be of an emotional nature: such as coming to terms with the illness and the inevitable death of the patient, or the need for on-going bereavement support.

Social workers/care managers are pleased to have any such case referred at as early a stage as possible. This will allow the most effective support both practical and emotional to be offered to the patient and the family for as long as necessary. The social worker/care manager can only become involved if the patient and family agree to have contact.



Information on how to contact a social worker/care manager is contained in Appendix 1.

5.5.3 Religious support

Relatives should always be offered appropriate religious support. Within the Christian tradition there are various denominations (Church of Scotland, Roman Catholic, Baptist, Scottish Episcopal etc). Some patients and relatives will be very clear about their faith and what form of ministry they wish to receive whilst others will not have given it any thought.



Some religious groups may like to have a minister or other religious adviser with them at the time of death to carry out religious rites. In some cultures relatives need to be involved in the death and immediate post death period. Helpful information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian). The text of this booklet is also available on the NHS Grampian Intranet. Further information and advice is available from hospital chaplains.

In certain specific circumstances such as an inquiry by the Procurator Fiscal (see Section 7.3 and Appendix 7) there may be a contradiction with religious practice. Hospital staff should make the police/Procurator Fiscal aware of any particular cultural requirements. When this is the case the legal requirement must be met but a full and sensitive explanation should be given to the relatives and every effort made to ensure that they understand the reasons for the action taken.

5.5.4 Spiritual support

Everyone, whether religious or not, needs support systems, especially in times of crisis. Appropriate spiritual support should be offered to bereaved relatives and carers whether they have specified religious beliefs or not, as part of a truly holistic approach to care. Spiritual care is not necessarily religious and is usually given in a one-to-one relationship, being completely person-centred. Hospital chaplains will help as necessary.

5.5.5 Hospital chaplains

Full-time hospital chaplains work in all the hospitals in Aberdeen. When a death is expected, or has already taken place within the hospitals, a chaplain is available 24 hours a day to provide spiritual religious and pastoral support to both relatives and staff. This can be in some or all of the following ways:

- By sitting quietly with relatives and sharing their time of hurt, loss and sadness. Because the chaplains have no strict timetable they are available to sit with relatives as long as they wish – for example while the body is being washed or while other relatives arrive or while the initial grief is being expressed in a way that is distressing to others present.
- By having a time of prayer either at the bedside, or in a private room or Hospital Chapel. Chaplains often find that many who claim no faith still wish a prayer commending the deceased into the hands of God and they find comfort in feeling that all that could have been done for their loved one has been done.
- Chaplains are also available to escort relatives to see the body if it is taken to the mortuary on the Foresterhill site. This can be helpful when, for example, the patient died through the night and some of the relatives were not present, but wish to have an opportunity of seeing their loved one within the peaceful atmosphere of the mortuary chapel. Chaplains are willing to accompany relatives to see the body at the funeral director's premises, if required.
- By responding to questions from relatives, such as: "What happens now?" and explaining the requirements to make contact with registrar, funeral director and, if appropriate, a minister, priest or religious leader of their choice. Help can be given with how to initiate these procedures if they are not familiar with the people concerned.
- By acting as an escort, if appropriate, to take home any relatives who live within reasonable distance of Aberdeen and who because of time or their personal distress are unable to make their own way home.
- By offering a continuity of care and support for relatives after a funeral
- By being available for staff who have been distressed by a particular death in the ward. Some members of staff find it easier to talk about their feelings with those who are not directly associated with them in the ward.

Hospital chaplains maintain a list of contacts for faith groups in the North East of Scotland and beyond.



Information on how to contact the hospital chaplains is contained in Appendix 2.

Part-time (sessional) chaplains serve all hospitals outside Aberdeen. These chaplains will try to provide a similar service to their full time colleagues, limited by the time they have available.

5.5.6 Scottish Episcopal Church, Church of England and other churches of the Anglican Communion

After the death of a patient of the Anglican Communion, a chaplain may say prayers with the patient and the family. Ongoing support for the family can be offered.

If the relatives choose not to contact a chaplain they should be advised to contact the Rector of their church as soon as they can.



Information on how to contact the Scottish Episcopal chaplain is contained in Appendix 2.

5.5.7 Roman Catholic Church

After the death of a patient who belongs to the Roman Catholic there is no need to call a priest to administer sacraments, since these are for the living. A deceased patient's relatives should be advised to contact their own priest as soon as they can. However, if relatives are still present in the hospital after a death a priest will be pleased to attend to offer pastoral support.



Information on how to contact the Roman Catholic chaplain is contained in Appendix 2.

5.5.8 Other faith groups



Helpful information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian). The text of this booklet is also available on the NHS Grampian Intranet. Further information about the practices of faith groups can be obtained from hospital chaplains who will help facilitate appropriate support for families and carers.

5.5.9 Leaving the hospital

It is desirable that relatives are accompanied to the hospital door when they leave the ward after the death.



When a relative has lived alone with a dying patient, staff should check if the relative is going back to an empty house and that someone will be there for company.

This is particularly important in the case of sudden, unexpected deaths. With the relative's consent it may be helpful to inform other relatives, neighbours, a minister or the family doctor to ensure that support and care is provided during the first few days of distress and shock.

5.5.10 Ongoing support

The support given by hospital staff to relatives after a death is normally very short term. However opportunities for continuing support exist.

Although some relatives may continue to keep in touch with ward staff, this will mainly be provided by those individuals and a variety of voluntary organisations which provide support and follow up in the community.



A list of useful contact numbers is included in **Section 11**

5.6 Concern for other patients in the ward

5.6.1 Telling other patients

After the next of kin has been informed, other patients in the ward or room should normally be told individually about a patient's death. Even though they may already know about it, this formal public acknowledgement of a death is very important to all patients. They may wish to talk to staff about the dead person and their feelings.



Attempts to deny a death or pretend it has not happened are likely to add to the fear and mystery which already surround death and are not helpful to other patients or to staff.

It is also important for other terminally ill patients to realise that their own deaths when they come will not be treated as if shameful or frightening. Even in death they will be cared for with dignity and respect.

5.6.2 Removing bodies from the ward

The removal of bodies should be carried out in a professional manner in line with the wishes of relatives. Meal times, staff change over periods or other unsuitable times should be avoided.

Consider other patients

Bodies should always be moved with dignity and respect. It is important to make as little noise as possible (for example noisy trolley wheels should be reported for maintenance).

In some wards it is traditional to draw curtains round all the beds when a body is removed. This apparently sensitive procedure can cause more distress to the other patients who can hear everything that happens, than the sight of a suitably covered trolley being taken from the ward in a dignified and respectful manner accompanied by a nurse.

Each ward should consider its policy. It may be decided to continue to draw curtains round certain patients' beds while the body is being removed, but this should not be done without telling the patients what is happening.

5.7 Last offices

The procedure for last offices was reviewed in 2009. (See Appendix 6) It is also available on the NHS Grampian Intranet.

Relatives may wish certain items of jewellery or faith symbols to remain with the patient (such as a wedding ring) and they may request the patient is dressed in nightclothes rather than a shroud. These wishes should be respected. This may be particularly important for members of certain faith groups. Information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian).

5.8 Viewing the body

5.8.1 Supporting relatives

Many relatives will wish to see a patient who has died in hospital and spend some time with the body. This should take place in a single room when possible. Bodies should not be kept in multi-bedded bays for prolonged periods. However it is important also to be sensitive to the wishes of those relatives who prefer not to do so. Staff should support the informed choice of the relatives. They should be informed that they can change their minds at any time and that they can see the body either in the hospital's mortuary or at the Funeral Director's premises.

Attention to detail

Relatives may wish to return several times to see the body before leaving the ward. Lasting impressions are formed at this time and the body should be thoroughly prepared for the relatives. A clean sheet and counterpane should cover the body, leaving hands accessible to the relatives. All medical

equipment whenever possible should be removed from the patient and the immediate area.

Before viewing the body relatives should be prepared for the experience in a sensitive manner. A member of staff should:

- Explore any fears or doubts the relatives may have.
- Offer to stay with the relatives while they view the body.
- Prepare the relatives for how the body might look or feel (such as being cold to the touch).
- Act as a role model by approaching the body and touching the body with a gentle and individual personal gesture, although this may not always be appropriate eg for Jewish or Muslim families etc.

Relatives should be encouraged not to feel embarrassed about showing their emotions. This can assist the grieving process. After seeing the body, relatives should be offered the opportunity to gather thoughts in privacy.

5.8.2 Mortuary viewing area at Foresterhill

The bodies of patients who die in hospitals on the Foresterhill site and at Roxburghe House are usually taken to the Foresterhill mortuary. Once the body has been removed from the ward it is still possible for relatives to arrange to visit the mortuary to view. The mortuary is behind the Medical School and is entered by its own door from the outside.

Relatives should be reassured that the mortuary viewing area is a pleasant and welcoming room.



Staff must telephone the mortuary first (extension: 52112), to arrange for the relatives to visit. If necessary the on-call anatomical pathology technician can be contacted out of hours. Information on how to call the anatomical pathology technician is contained in Appendix 4. The deceased will have to be prepared for viewing but this should take no more than 15 minutes under normal circumstances. Please note if the death has been reported to the Procurator Fiscal, permission has to be sought, and cannot be guaranteed, from the investigating officer before the deceased can be viewed in the mortuary. The mortuary is staffed from 8am to 5pm Monday to Friday, and 8am to 1.00pm on Saturdays.

It is good practice for a member of the nursing staff known to the relatives to accompany them to the mortuary. When this is not possible, the Aberdeen Royal Infirmary hospital chaplains have offered their services. Anatomical pathology technicians will have prepared the body and placed it in the viewing room. Nursing staff may either accompany the relative or wait outside the viewing room. Relatives can speak to the anatomical pathology technicians if they have any questions about making funeral arrangements or other post mortem issues.

In Procurator Fiscal cases the body may eventually be transferred to the mortuary at Queen Street where there are no suitable viewing arrangements other than for formal identification.

5.8.3 Mortuary at Woodend Hospital

The bodies of patients who die at Woodend Hospital are taken to the mortuary there. Due to the location of the mortuary, relatives are first offered the opportunity to view the deceased in the ward where they passed away. Viewing at the Woodend mortuary is not permitted outwith office hours due to its location and staff availability. Relatives are then advised to view the deceased at the funeral director's premises.

5.8.4 Mortuaries at Elgin

The bodies of patients who die in hospital on the Dr Gray's site are usually taken to the Mortuary. Once the body has been removed from the ward it is still possible for relatives to arrange to visit the mortuary to view. Relatives should be reassured that the mortuary viewing area is a pleasant and welcoming room.

Staff must bleep the porter first, (bleep 635), to arrange for the relatives to visit. This can happen any time of the day or night. The deceased will have to be prepared for viewing but this should take no more than 15 minutes under normal circumstances.

It is good practice for a member of the nursing staff known to the relatives accompany them to the mortuary. The porter will have prepared the body and placed it in the viewing room. Nursing staff may either accompany the relative or wait outside the room.

In Procurator Fiscal cases the body will be taken from the ward/department to the mortuary at Spynie Hospital. Permission has to be sought and cannot be guaranteed, from the investigating officer before the deceased can be viewed in the Spynie mortuary.

5.8.5 Arrangements at other hospitals

Arrangements are in place in hospitals other than on the Foresterhill site, Woodend Hospital and in Elgin for funeral directors to uplift bodies of patients who have died direct from the ward or from the mortuary. Relatives must contact the funeral director to arrange to see their relative once the body has been moved from the ward.

5.8.6 Trauma and viewing

The bodies of people who have died as a result of trauma will for all practical purposes always come within the jurisdiction of the Procurator Fiscal and, as is usual in these circumstances, close contact or cleaning will be discouraged for forensic reasons. Relatives may be asked to carry out a formal identification and this may take place at Foresterhill mortuary. At Dr Gray's formal identification may take place within the department depending on the police officers dealing with the case. The majority of identifications take

place at Spynie Mortuary. Sometimes this identification will need to be carried out behind glass depending on circumstances. In general it is desirable that relatives should view the body since this seems to help them to accept the reality of death. However it is recommended that viewing of such bodies subject to trauma should be carried out at the most appropriate time and this may mean being delayed until after the post mortem examination has been performed and the funeral director has attended.

5.9 Sudden or unexpected death

Sudden death in hospital is particularly stressful for all concerned. Relatives have not had time to come to terms with and to prepare themselves for the finality of death. Equally there may be little or no opportunity for a rapport to develop between the relatives and staff.

A sudden or unexpected death can be very difficult to accept and may leave long term emotional scars. Staff may find it very difficult to establish a relationship with relatives in such cases since they are often shocked, disorientated and anxious. Hospital staff may need to provide special support for relatives and to notify other health service, social work and appropriate agencies in the community.

Information and support

It is particularly important in these cases that a named senior doctor or nurse is assigned to look after the patients and their relatives. They should keep the relatives informed of developments, support them, give them an opportunity to talk and ask questions, co-ordinate all arrangements and contact the patient's general practitioner. The family should be assured of a welcome should they wish to ask questions at a later date.

The following section refers specifically to Accident and Emergency Departments. Much of its guidance will also apply in other areas.

5.10 Sudden or unexpected death in Accident and Emergency departments

Although the guidelines in this document are appropriate for the care of all bereaved, sudden or unexpected deaths can present particular problems.

The events and impact of sudden or unexpected death on relatives can produce bewilderment, protest, fight or flight. It may immobilise or energise responses and produce erratic and disordered behaviour.

5.10.1 Facilities

In an Accident and Emergency department where there may be a large number of relatives, a room should be available to accommodate them where privacy can be provided without creating a sense of isolation. It should be comfortable, with facilities such as, a telephone with direct access for incoming and out-going calls, a telephone directory, tea and coffee making facilities and toys for children etc. Toilets should be *en suite* or adjacent/nearby.

5.10.2 The role of the named nurse in supporting the relatives

Whenever possible a named nurse should be allocated to the relatives on arrival. It is essential to attempt to establish rapport as soon as possible. Building a relationship and communicating effectively with shocked, disorientated and anxious relatives can be difficult. The named nurse will keep relatives informed about the patient's condition and prepare them for a possible death.

If the relatives were not present when the emergency occurred, they may have difficulty in accepting the identity of the patient. Understanding this will help the nurse in communication with the relatives.

The named nurse should monitor the events in the resuscitation room, keep relatives informed of what has happened, what is happening and what may happen. The named nurse should encourage the medical staff to break bad news without delay and without the use of euphemisms.

The role of the named nurse is exclusively to care for the relatives.

5.10.3 Breaking bad news

It is very important to allow relatives to have time to assimilate the news of the death and to react immediately to their grief. Nursing staff should be prepared for a wide range of reactions which may include denial, disbelief and anger, sometimes in exaggerated forms. Breaking bad news over the telephone should be avoided whenever possible. When relatives cannot attend the department, the co-operation of the local police or general practitioner is sought to give the news personally to the relatives in their



home. The police should be supplied with a name and telephone number of a member of hospital staff who will be able to answer any questions which the relatives may have (Grampian Police non-emergency telephone number 0845 600-5-700).

5.10.4 Viewing the body

A separate room offering peace and privacy for an unhurried viewing of the body is highly desirable.

Relatives should be given where possible the opportunity of seeing the place of death. This can dispel the feelings of disbelief and denial that they may be experiencing.

Clean clothing and bed linen which do not display the hospital logo or name should be used for body covers. The body should be prepared in a way that makes it easy for relatives to touch and hold.

For infants and smaller children a Moses basket or similar carrier should be available.



Appropriate religious and cultural support should be offered to the relatives. The named nurse with the assistance of the hospital chaplains should facilitate any specific religious requests. Helpful information is available in the booklet, *Religions and Cultures in Grampian* (a practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian). The text of this booklet is also available on the NHS Grampian Intranet. Further information and advice is available from hospital chaplains.

Relatives should not be hurried and should be allowed to see the body if they wish. However, staff should also be sensitive to the wishes of those relatives who prefer not to view the body. Appropriate information about the appearance of the body (for example severe facial injuries following trauma) is essential to enable the relatives to make an informed decision about viewing the body.

The named nurse may act as a role model by touching and talking to the body and encouraging the relatives to do likewise as such contact can assist in the grieving process. However, in certain circumstances, (for example with Muslim or Jewish patients) this may not be appropriate.

Personal mementos should be offered to the relatives, for example a lock of hair and an offer made to provide a photograph of the person who has died, although this may initially be refused. In this instance the photograph should be filed in the patient's notes, as many relatives return for it at a later date.

5.10.5 Patient's property

In certain instances the police may require to retain the patient's property. The named nurse should ascertain if this is the case and explain it to the relatives.

Care of the clothing and valuables is very important. Clothes should be folded and placed in the carrier bag provided for this purpose. Often the clothing will have been soiled, damaged or cut. This should be explained in advance to the relatives and, if they wish, the clothing kept for disposal in the department. Rings and jewellery should be placed in the special trinket boxes supplied. When possible valuables such as wallets, cheque books and keys should be handed to relatives in hospital property envelopes. To avoid the potential for accusations of misuse of patients' property at a later date it is essential to gain a signature for all property that is returned or disposed of in line with health board policy. It is a common wish for the wedding ring to remain on the finger. The named nurse should ask if the relatives wish it to remain. When the relatives do wish the ring to remain, it must be taped to the finger and this documented on the patient's Accident and Emergency department record and indemnity form.

Supplies of the carrier bags and trinket boxes are held by central stores.

5.10.6 Information for relatives

All sudden or unexpected deaths must be reported to the Procurator Fiscal. It is the responsibility of the medical or nursing staff in Accident & Emergency department to report a sudden or unexpected death to the police who act as agents for the Procurator Fiscal. The Procurator Fiscal will then decide whether he wishes to have a post mortem examination carried out. In collating the necessary information for the Procurator Fiscal, the police will make extensive enquiries including interviewing the relatives and other relevant people. This can be facilitated in the Accident and Emergency department or in the relative's house.

The named nurse will inform the relatives and facilitate any interviews within the department.

The named nurse will inform the relatives that:

- In the event of the Procurator Fiscal requiring a post mortem examination, the body will be transferred to the hospital mortuary and then taken to the local authority mortuary.
- The police will contact the relatives to inform them that the death certificate is ready for collection.
- The funeral director will arrange to collect the body from the local authority mortuary whenever the Procurator has issued the death certificate.

- In the event of the general practitioner issuing the death certificate, the relatives can arrange for a funeral director of their choice to collect the body from the mortuary.

The named nurse will also provide:

- Information about the death certificate
- Details about when funeral arrangements can be made.
- Information about where the bereaved can seek support.

This is supported by literature contained in the NHS Grampian Bereavement Folder.

Relatives should be encouraged to contact the department if they have any questions or concerns or just wish to discuss the events again. The named nurse will offer written information naming appropriate members of nursing and medical staff who may be contacted and a contact number. An offer should be made to the relatives to help with travelling arrangements home. The named nurse will escort the relatives to the door of the department where possible avoiding the main waiting areas.

5.11 Sudden death in theatre or during medical procedures

Death of patients in a theatre environment or while undergoing medical procedures requires special consideration. Death during elective surgery and procedures does not happen often and is not usually associated with care of relatives as the body will be transferred to the mortuary and ward staff offer support to the relatives, deal with the return of belongings etc. Death as a result of emergency surgery (for example following a road traffic accident) can occur more frequently.

In these cases staff may be offering care of relatives in an environment which is alien to them. Staff may have to accompany relatives to view their deceased relative within a theatre environment which can be extremely traumatic for both parties. Senior staff should ensure that adequate support is offering to relatives, making use of hospital chaplains if appropriate, and to staff involved in the incident.

The general advice offered in section 5.9 (Sudden or unexpected death in Accident and Emergency departments) may be helpful.

5.12 Informed decision about organ and tissue donation

5.12.1 The role of the Donor Transplant Co-ordinator

The Donor Transplant Co-ordinator will be able to give help and advice about organ and tissue donation. Staff should consult the Donor Transplant Co-ordinator before relatives are approached. At this time, the Donor Transplant Co-ordinator will also assist in consulting the NHS Organ Donor Register and ascertain whether the potential donor has registered their wishes.



To contact the Donor Transplant Co-ordinator call **0845 456 6000** (NHS Grampian switchboard) **and ask to speak to the Donor Transplant Coordinator on call.**

5.12.2 When to offer organ/tissue donation

Staff should follow the **United Kingdom Hospital Policy for Organ and Tissue Donation (2003)** which provides information and support for healthcare professionals to ensure that all families are approached by skilled and experienced personnel, in a sensitive manner and at an appropriate time.



The request for donation should be made when the relatives have understood that death is imminent or has occurred. An appropriate time may be after the relatives have been informed of the results of the first set of brain stem death tests, as in an intensive care setting. The diagnosis of brain stem death has to fulfil the clinical criteria as set out in the **Code of Practice for the Diagnosis of Brain Stem Death (1998)**

The Donor Transplant Co-ordinator would not normally discuss the possibilities of organ donation with relatives until diagnosis, prognosis and concept of brain stem death have been discussed by medical and nursing staff within the intensive care unit. Sometimes the Donor Transplant Co-ordinator may discuss organ donation with relatives before brain stem death has been formally diagnosed when the relatives indicate a willingness that organs be donated. (**United Kingdom Hospital Policy for Organ and Tissue Donation 2003**).

5.12.3 Brain stem testing



The patient undergoes two sets of brain stem death tests, as recommended by the **Code of Practice for the Diagnosis of Brain Stem Death (1998)** and the time of death is recorded as the first set of tests. The relatives are fully informed throughout this process by hospital staff and are given time to understand this information before being approached about organ/tissue donation.

5.12.4 Offering the option of organ/tissue donation



Organ/tissue donation is a positive option and can be a comfort at times of great distress. In not offering the relatives the option to donate, healthcare professionals may be depriving them of the opportunity to find comfort during their time of grief. For this reason it is essential that prior to the relatives being approached, the Donor Transplant Co-ordinator be contacted so they may establish the patient's suitability for donation.

The Donor Transplant Co-ordinator will undertake a risk assessment on all potential donors to minimise the transmission of infections and disease. **(Code of Practice for the Diagnosis of Brain Stem Death [1998]).**

A good deal of time may therefore be needed for discussions with relatives and increasingly so when organ donation is to take place. Relatives are given the opportunity to ask questions about donation, before making their decision to donate. The explanations given to relatives are therefore very important.

The relatives are thanked in a sensitive manner and are offered further assistance in meeting any other needs that they may want addressed at this time. Any information relating to the approach and outcome of discussions with relatives is documented in the patient's medical records.

5.12.5 Authorisation

There is no legal requirement in Scotland currently to gain consent to donation if the deceased's wishes are known, but it is usual to gain authorisation from the nearest relative(s). Efforts should be made to establish that the deceased had not expressed unwillingness to donate. Scotland currently operates an "opt-in" system of consent, based on The Human Tissue (Scotland) Act 2006. "Authorisation" is ascertained by the Donor Transplant Co-ordinator in consultation with the relatives

5.12.6 Talking to relatives



Some relatives may object to donation, despite knowing their relative's wishes by way of registration on the Organ Donor Register/carrying a donor card / expressed wish/ known entry within a Will. In these situations any concerns or objections raised by relatives are openly discussed and their opinions may possibly take priority over the patient's wishes. Following this discussion with the Donor Transplant Coordinator the relatives are then required to sign the appropriate **Withdrawal of Authorisation** document,

5.12.7 Follow up care

The Donor Transplant Coordinator will be present throughout the donation process and will undertake last offices and the transfer of the patient to the mortuary or funeral director. Follow-up support is provided to those relatives who express a wish for further contact. Likewise, healthcare professionals involved in the care of the patient also receive similar information

Further information on Organ and Tissue Donation and Transplantation can be found on the UK Transplant Website: www.uktransplant.org.uk

5.13 When there is a stillbirth, neonatal death or the death of a baby of less than 24 weeks' gestation



There are two detailed documents available from Rubislaw ward at Aberdeen Maternity Hospital called: ***When a baby is stillborn – Staff Information Pack and Guidelines***” and ***“Death of a Baby Younger than 24 Weeks Gestation” - Staff Information Pack and Guidelines*** which gives detailed information, advice and suggestions on how to care for families when a baby dies.

Care is usually focused in Rubislaw Ward, Labour Ward, the Neonatal unit and at Ward 3 Dr Gray’s Hospital, although the mother may be a patient in another ward and consequently all maternity staff should be familiar with how to support families in these distressing situations.

Relatives should be offered a hospital post mortem when a baby dies or is stillborn. Midwives in Rubislaw Ward and Ward 3 at Dr Grays have had training in discussing options with the family and they can give advice on completing authorisation forms as well as mortuary staff.

Care usually involves giving families the opportunity to spend time with their baby; taking of photographs; recording baby hand and foot-prints; giving locks of hair; issuing the special certificates; offering entries in the hospital's Memorial Book; offering to assist with funeral arrangements; offering the help of the hospital chaplains in the event of a stillbirth and/or social worker/care manager; and offering return visits, when appropriate.

Funeral arrangements

In the event of stillbirth the hospital offers to help the family make funeral arrangements. This might be the burial or cremation of the baby at the hospital's expense in ground set aside for this purpose. In Aberdeen this is at Hazlehead Cemetery or Aberdeen Crematorium. Although the funeral arrangements are free to the family, there will be a charge for any inscription on the headstones provided at Hazlehead Cemetery. In Elgin the burial will be in Elgin cemetery or a cremation at Moray crematorium. There is no cost for the family.

Unless families make other arrangements the hospital will arrange, with the family’s permission, for the cremation of the bodies of babies who died at under 24 weeks' gestation. A Memorial Service for these babies is held 4 times a year at Aberdeen Crematorium to which families and staff are invited.

Parents can always make their own arrangements for their baby's funeral, whatever the gestation. Most Funeral Directors will arrange the burial or cremation free of charge, although there will usually be a charge for the purchase of a lair (plot) at a cemetery and the local authority may charge for opening the grave.

Chaplain

A hospital chaplain is always on call, available to give pastoral support and advice. In cases of clinical emergency contact the chaplain if baptism is requested. In the event of a stillbirth, chaplains sometimes hold an informal service of blessing for the baby.

Communication

The mixed emotions of birth and death may be traumatic. Since parents whose baby has died often wish to return home quickly, good communication between community and hospital based services is of critical importance.

5.14 When a child dies



5.14.1 NHS Grampian Combined Child Health

Staff follow a local procedure, *When A Child Dies* guidelines for staff.

5.14.2 Guidelines for staff in the event of the sudden death of a child

5.14.2.1 Care of parents whose child dies suddenly or unexpectedly

The sudden or unexpected death of a child is probably the most traumatic experience that parents may have to endure. It is essential that they are supported and given the privacy to absorb this distressing event. Parents may find it difficult to express their feelings. They need time to react, to ask questions, and where possible to be with their child, alone (see paragraph 3 below re police/fiscal) or with extended family. It is only with experience, that staff learn how to respond to these needs. A professional and sensitive approach is needed to offer compassion, supportive care and at the same time assess the immediate wishes of the family

On arrival in A&E or the ward the parents and other family members are shown into an appropriate private room and offered refreshments whilst a review of the situation is made. At the discretion of the medical team or nurse in charge it may be possible for the parents to stay with their child during resuscitation if they wish. This needs careful handling and a member of staff is required to be with them to explain what is happening and support them through a very difficult experience.

If there is any suspicion that death is not from natural causes the police must be informed immediately. They may require to take possession of the child's body at an early stage. Once death of the child is confirmed and the police have given any necessary instructions an assessment is made as to the best place for the parents to be with their child in order to comply with these instructions. The procurator fiscal may require staff to be in attendance of the child with the family at all times. This requirement must be met with the upmost sensitivity for the family.

If the body is not required to be removed by police immediately the family must be given as much time as they need to be with their child. This may be in the viewing room in A&E or the palliative care suite on the 2nd floor if available. The length of time which is deemed the maximum (for infection control reasons) is approximately 12 – 24 hours, depending on heat of the room. It is important that a member of staff involved in the child's care is available to the family throughout this time.

When the parents are ready to leave the hospital, check they have somebody to take them home. A bereavement pack is given to the family (see section 4). This reinforces what they have been told by staff and police and also contains the name of their nurse and a hospital contact number should they require help or need to speak to someone.

The checklist in section 5 should be followed to ensure all appropriate personnel are contacted and that this is documented in the notes.

5.14.2.2 Care of the Body (Last Offices)

(See the Appendix 6 for more detailed instructions on last offices)

In suspicious circumstances, the police will inform you what procedures you may or not do with the body. If allowed you can then make the child presentable to the parents e.g. wash their face and hands, dress any wounds as required with elastoplast dressings or pads and bandages to prevent any soakage. **Any lines drains or tubes must be left in place for cases reported to the procurator fiscal.** Dress the child in a baby-gro, night dress or pyjamas and wrap in a shawl/blanket. Discuss with parents what they might like to have as a keepsake. Photographs, hand/ footprints and a lock of hair may be taken after a faith/cultural assessment (e.g. the hair of a Muslim should not be cut after death.) **If the parents are not present to discuss their wishes do not take any keepsakes.** The police may wish to take the clothes the child was wearing. They should be placed in an evidence bag which A&E stock and the parents informed they will be returned by the police as soon as possible.

5.14.2.3 Viewing the body

If the body of the child is not required to be removed early by the police the parents and families will be allowed to spend time with their deceased child. In Accident & Emergency there is a private viewing room. In the other parts of the hospital a single room will be utilised. The palliative care suite on the 2nd floor could also be used for this purpose by any area if it is available. Staff must be close to whichever room is chosen (or with the child at all times if directed to be so by the police or procurator fiscal) in order to offer help and support to the parents.

5.14.2.4 Documentation and final procedure

Once the family has left, attach completed name band (containing date and time of death, name CHI number date of birth and ward) to wrist. Leave original name band in situ if present. If original name band was not in place put a second name band on with the same details on. A registered nurse must check both name bands. Wrap the body in a sheet and fasten with 2.5 cm zinc oxide tape. In cases of infection or where there may be soakage a body bag should be used. Complete the mortuary label and tape securely to the sheet. If there is any infection an infection control notification should also be attached. Once child/baby is ready to be transferred to the mortuary, contact the porter on ext 52967 bleep 2710 to arrange the transportation. A Moses basket pram or trolley/bed may be used depending on the size of the child.

Complete the Notice of Death Slip. Send one copy to Medical Records and retain one in the book.

5.14.2.5 Procurator Fiscal

It is the Procurator Fiscal who decides whether a fiscal post mortem examination will take place. If this is the case the body may be transferred from the hospital mortuary to the Council Mortuary at Queen Street, where there are no visiting facilities. The police will remain in contact with the parents and keep them informed. In this case it is only the procurator fiscal who issues the death certificate. It is the responsibility of the medical staff to report the death to the procurator fiscal and then to discuss with the parents the outcome and how this will affect the funeral arrangements. If the Procurator Fiscal does not require a post mortem, the family can be offered a hospital post mortem.

5.14.2.6 Organ donation

Staff may be approached by relatives offering the child's organs for donation. In these circumstances the request should be directed to the child's consultant who will discuss the request with the relatives

5.14.2.7 Telephone enquiries

Any telephone calls from 'concerned' others are referred to the nurse in charge.

5.14.2.8 Unexpected deaths in theatre

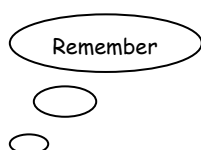
It is most unusual for deaths to occur in theatre and as such any death is likely to lead to an investigation by the procurator fiscal. Someone senior in the ward where the child was must be informed of the situation and told who is going to inform the parents.

The senior theatre staff or medical staff will contact the chaplain. The medical staff inform the parents of the situation and give them the option to view the child in theatre. Member/s of theatre staff must remain with the child and family.

The procedure for care of the family and child's body is then as above for an unexpected death anywhere else in the hospital. The wards and A&E have 'Last Offices Boxes' which can be borrowed with the relevant information & equipment in.

5.14.3 Guidelines for staff in the event of the expected death of a child

5.14.3.1 Care of the child and family



The parents and immediate family may have been in hospital awaiting this event. They will need privacy to hold the child and be together for some time. The palliative care suite may be an appropriate location for this to take place. Staff need to be close to the room to offer any help support and meet requests the parents may make.

The checklist on page 58 should be followed to ensure all appropriate personnel are contacted.

5.14.3.2 Care of the body (Last Offices)

(See Appendix 6 for more detailed instructions on last offices)

The parents may wish to help the nursing staff wash and dress their child. All wound sites need to be padded and dressed as necessary. The parents may have chosen special clothes for their child. Photographs, hand/footprints and a lock of hair may be taken after a faith/cultural assessment and discussion with the parents (e.g. the hair of a Muslim should not be cut after death.) **If the parents are not present to discuss their wishes do not take any keepsakes.**

5.14.3.3 Care of the body

The child should be moved to a single room if not already in one and parents given as much time as they need with their child. The length of time which is deemed the maximum (for infection control reasons) is approximately 12 – 24 hours, depending on heat of the room. It is important that a member of staff involved in the child's care is available to the family throughout this time.

When the parents are ready to leave the hospital, check they have somebody to take them home. A bereavement pack is given to the family (see section 4). This reinforces what they have been told by staff and also contains the name of their nurse and a work contact number should they require help or need to speak to someone.

5.14.3.4 Documentation and final procedure

Once the family has left, attach completed name band (containing date and time of death, name CHI number date of birth and ward) to wrist. Leave original name band in situ if present. If original name band was not in place put a second name band on with the same details on. A registered nurse must check both name bands. Wrap the body in a sheet and fasten with 2.5 cm zinc oxide tape. In cases of infection or where there may be soakage a body bag should be used. Complete the mortuary label and tape securely to the sheet. If there is any infection an infection control notification should also be attached. Once child/baby is ready to be transferred to the mortuary contact the porter on ext 52967 bleep 2710 to arrange the transportation. A Moses basket pram or trolley/bed may be used depending on the size of the child.

Complete the Notice of Death Slip. Send one copy to Medical Records and retain one in the book.

5.14.3.5 Mortuary

The parents or other family members may wish to visit the child in the hospital mortuary. This needs to be arranged with the Anatomical Pathology Technician (mortuary staff) [see Appendix 4 for contact details]. The family should be accompanied by a nurse from the ward. If this is not possible one of the hospital chaplains should be contacted to ask for their assistance in this matter.

5.14.3.6 Transfer of the child to their own home

The parents may wish to have their child's body taken to their home. The ward staff should assist the parents to make contact with a funeral director of their choice. Arrangements can be made with the funeral director to transport the child to the family home. This may be in a coffin or lying in the funeral director's car covered for example in a 'Linus Quilt.' Alternatively the family may wish to take the child's body home themselves in their own car which is perfectly acceptable. A letter from senior medical staff stating the child died in hospital should be given to them to travel with. A Moses basket, pram or bed (depending on the age of child) should be used to move the child to the vehicle they are leaving in. During the Emergency Care Centre build the exit from Royal Aberdeen Children's Hospital is via the ambulance entrance. When the build is complete, exit is proposed to be through rear Royal Aberdeen Children's Hospital door.

If a child's body is not being transferred to the mortuary it must never be allowed to leave the hospital until the Anatomical Pathology Technician (Mortuary Staff) has been contacted (see Appendix 4 for contact details). This must happen any time day or night.

5.14.3.7 Procurator Fiscal

It is the Procurator Fiscal who decides whether a fiscal post mortem examination will take place. If this is the case the body may be transferred from the hospital mortuary to the Council Mortuary at Queen Street, where there are no visiting facilities. The police will remain in contact with the parents and keep them informed. In this case it is only the procurator fiscal who issues the death certificate. It is the responsibility of the medical staff to report the death to the procurator fiscal and then to discuss with the parents the outcome and how this will affect the funeral arrangements. If the Procurator Fiscal does not require a post mortem, the family can be offered a hospital post mortem.

5.14.3.8 Post mortem examinations

Post mortem examinations play a very valuable role not only in giving information about individual patients but also as a final check on many aspects of clinical care. All reasonable efforts should therefore be made to obtain permission for post mortem examination when this is appropriate.

If there is any doubt about the desirability of having a post mortem examination performed, the doctor must contact with the child's consultant. It is a medical responsibility to ask for and obtain consent for a post mortem examination which is carried out by a paediatric pathologist.

5.14.3.9 Organ donation

Staff may be approached by relatives offering the child's organs for donation. In these circumstances the request should be directed to the child's consultant who will discuss the request with the relatives.

5.14.3.10 Telephone enquiries

Nursing staff should establish with the parents what response they wish to be given in the event of telephone enquires following the death of their child. Record in the notes what this response should be. This should also include what information they wish other parents of children on the ward to be given.

5.14.4 Guidelines for staff in the event in the event of an expected death of a child at home

The parents and immediate family may have been at home awaiting this event. For children whom this is an expected event, plans will have been made between the family, the community staff and the acute hospital staff how to manage the event in the best way for the family. If the family think the child is about to die and want someone to be with them, there will be a named person available (a nurse or doctor) 24 hours a day to call. The GP or funeral director does not need to be called immediately, particularly when family want some time on their own with their child.

The family may wish to choose what their child is going to wear and whether they wish to dress them themselves or would prefer someone else to do this for them. Brothers and sisters can feel left out - find out what children know as this can open up conversation. Children's experience of death depends on their age and past experience. Try to respect the child's wishes and those of brothers and sisters.

A lock of hair can be placed in a card, hand/foot prints, photographs can be taken if family wish, after a faith/cultural assessment (e.g. the hair of a Muslim should not be cut after death).



Families have different religions and cultures and you can refer to '*Religions and Cultures - Guide to Beliefs and Customs for Health Staff and Social Care Services*' or the on-call chaplain for advice. The GP will issue the death certificate at home.

Assistance should be given to parents to make contact with a funeral director of their choice. The family's religious advisor or Chaplain at the hospital can give names of funeral directors with experience of children's death and funerals.

The child can stay at home with family for some or all of the time before the funeral if this is what the family want. It is worth taking advice from a funeral director; particularly in warm weather conditions.

The funeral director can provide a coffin for the child. The family may want to place favourite toy or possession in coffin.

Some funeral directors put make up on children; if the parents do not wish this to occur they will need to inform the funeral director of this request. The child's body can be taken to the funeral director's chapel of rest. The family can see their child there, can talk to their child and touch them, or to pray or carry out any religious practices that are important to them.

Support is always available. Contact numbers will be left with the family. The death of a child must be registered within five days. Registrar Offices are open Monday to Friday.

5.14.5 Contents of Bereavement Pack

- i. *What To Do After A Death In Scotland*
- ii. *Help For You Following A Bereavement* – an NHS Grampian publication
- iii. either
 - Information for Parents from A&E for a sudden death – “Child” or “Baby” # or
 - Information for Parents from wards for an expected death “Child” or “Baby” #
- iv. Bereaved Families Support Group Information Leaflet #
- v. Chapel Memorial Book Application Form
- vi. Annual Candle Service card

Supplies of all these leaflets are available from A&E at Royal Aberdeen Children's Hospital. Spare copies for wards are in the Bereaved Families Support Group Cupboard in the quiet sitting room, Parents Accommodation. These leaflets will be updated in the near future and their titles may change slightly.

6. Support for staff

Staff as well as relatives often experience grief and stress when dealing with death and bereavement. For some staff this may be their first experience of death or they may themselves have experienced a recent bereavement. Like relatives they may experience fear, vulnerability and insecurity.



Staff are not immune to the natural feelings present at a bereavement such as sorrow, hurt, anger and perhaps inadequacy as they try to cope with death.

Staff may find it helpful to make time to listen to one another. Peer support is essential to the well-being of those involved. It can be useful to provide an opportunity for talking through the experience together.

Debrief

When staff have been particularly distressed by a death or the circumstances have been unusual, a senior member of the team should provide an opportunity for those involved to meet informally to review what happened and to discuss their feelings.

Some staff may find it helpful to seek support from their line manager, Occupational Health staff, a hospital chaplain, a social worker/care manager or one of the Macmillan nurses.

Administrative and other procedures after a death

Checklist:

1. Do all staff know the hospital policy concerning release of information following a patient's death? (5.4)
2. Are death certificates completed and handed over promptly to relatives? (5.2.5, 7.5)
3. Does the doctor handing over the death certificate take time to discuss its contents with the relatives? (5.2.3, 5.2.5, 7.5)
4. Do all nursing staff know the hospital policy for returning deceased patients' property to relatives? (7.9)
5. Is the return of the deceased person's property dealt with in a sensitive manner? (7.9, 5.10.5)
6. Are staff, both medical and nursing, aware that families can be offered a hospital post mortem? Do they know where all the information is kept on their ward and that they have the correct authorisation forms? (7.6, Appendix 7)
7. If a post mortem examination is requested, who is responsible for explaining this to relatives? Are relatives always offered the opportunity to read the appropriate Post mortem information and to be informed of the results? (7.6)
8. Is the system for dealing with cremation papers understood, and are these completed within 24 hours? (7.7)
9. Do staff understand the criteria for involving the Procurator Fiscal's office? (7.4, 5.10.6, Appendix 5)
10. If death occurs in hospital, who is responsible for informing the deceased patient's general practitioner and, if appropriate, the referring doctor of the patient's death? (5.2.7, 5.3, 7.3)
11. What system exists for informing the Medical Records or other hospital Departments and do staff know of it? (5.3)

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7. Administrative and other procedures after a death

7.1 Giving information to relatives



Not all relatives are familiar with the administrative procedures surrounding death and may welcome guidance through the system. Administrative procedures should be carried out as smoothly and efficiently as possible so that no unnecessary distress or delay is caused to relatives. Appropriate literature should be given to relatives (eg the NHS Grampian Bereavement Information Folder which contains the booklet ***What to do after a death in Scotland practical advice for times of bereavement*** (published by the Scottish Executive Justice Department,) the death certificate (if it is available at that time), the NHS Grampian booklet ***Help for You Following a Bereavement*** and any other local literature.)

7.2 Procedures for death in hospital and community

Local hospital procedures should be followed to inform relevant departments of the death of a patient. This may be by means of duplicate Notice of Death book. This will allow booked appointments etc to be cancelled and will allow the medical records department to update their records.

Staff should be familiar with and follow local procedures for deaths which happen in community hospitals or at home. There are varied arrangements with General Practitioners and GMED. In some areas verification of death agreements are part of the community nurse remit

7.3 Notification of death to general practitioners

If a patient dies in hospital, the nurse in charge of the ward must inform the patient's general practitioner of the death as soon as possible. In certain cases it may be more appropriate for the doctor to inform the general practitioner.

If the death occurs out of hours, then the general practitioner should be informed the next day or as soon as possible.

7.4 Procurator Fiscal cases

The Procurator Fiscal's office will be involved in the following:

- Any uncertified death - ie cause unknown
- Any death which is sudden, suspicious or unexplained
- Any death resulting from unnatural causes e.g. accident, suicide, injury and all deaths where there has been a fracture.
- Any death during surgery and/or anaesthesia

- Any death which might be thought to be due to surgical/medical mishap
- Certain child deaths as defined in Appendix 7



Full details are contained in Appendix 5, ***Death and the Procurator Fiscal***.

It is the responsibility of the doctor concerned to notify the Procurator Fiscal's office as soon as possible after the death. The Procurator Fiscal's office will advise how to proceed. In circumstances when the Procurator Fiscal does not permit the issuing of the death certificate by a doctor, the relatives must be informed of the consequences of this decision: eg possible delay in issuing a death certificate and the funeral as well as a visit to the relatives by police officers, removal of the body to the local authority mortuary and the formal identification of the body. (There are no viewing facilities in the local authority mortuary at Queen Street in Aberdeen other than for purposes of official identification.)

7.5 Death certificate

Is the Procurator Fiscal involved?

First, it must be decided if the Procurator Fiscal is involved. The Procurator Fiscal should be consulted if there is any uncertainty or ambiguity. In all cases (except a Procurator Fiscal case) the death certificate can be completed immediately after death. It should be completed after discussion with a senior member of medical staff.

7.6 Post mortem examination requested

Consider a post mortem

Post mortem examinations play a very valuable role not only in giving information about individual patients but also as a final check on many aspects of clinical care. All reasonable efforts should therefore be made to obtain authorisation for a post mortem examination when this is appropriate. Families may ask for a post mortem to be carried out and this should not be discouraged.

The doctor, preferably the most senior clinician available responsible for the patient should spend time explaining to the relative(s) why a post mortem examination would be desirable. The doctor should allow the relatives to read the documents ***Post-Mortem Examination of an Adult Information Leaflet*** and the ***Further Information Leaflet*** if they wish and answer any further queries before going through the post mortem examination agreement form section by section. After completing as appropriate, the form must be signed by the next of kin or a nominated representative and be countersigned by the member of staff gaining consent. Relatives should be given a copy of the form so they have a record of what they have agreed to. In certain circumstances (for example where the next of kin cannot travel to the hospital easily either due to distance or infirmity) it may be necessary to gain permission for the post mortem examination by using a local GP.

The form can then be faxed to the mortuary and the original delivered at a later date so as not to delay the post mortem and therefore the funeral.

If a post mortem examination is required, the doctor must inform staff in the mortuary. The doctor must arrange for the deceased's case notes, post mortem examination request form and the agreement form to be taken to the Mortuary as soon as possible. The post mortem examination will be carried out at the earliest opportunity to minimise any delay to funeral arrangements.

Should there be a degree of urgency to have the post mortem examination performed, this should be discussed with the pathologist in charge of post mortem examinations. This may be particularly important for Jewish, Muslim and other religions which require burial within 24 hours. Hospital post mortem examinations should not delay funeral arrangements.

Relatives may refuse permission for a full post mortem examination but may accept a limited examination. If this is the case it must be clearly indicated on the form. Relatives should be aware that a limited examination may not give a full explanation of the cause of death.

At **Royal Aberdeen Children's Hospital** and **Aberdeen Maternity Hospital** there is a slightly different form and arrangements are made directly between medical staff and the paediatric pathologist or mortuary staff.

At **all other hospital sites within Aberdeen** medical staff contact the Mortuary or the Procurator Fiscal if required. Mortuary staff will arrange for portering staff to collect the deceased along with case notes, agreement and authorisation forms.

At **Dr Gray's Hospital** and **other hospitals outwith Aberdeen** paperwork should be completed as stated above.

Important points for arranging a hospital post mortem examination in Aberdeen.

Relatives must be made aware that the deceased will have to be transported to Aberdeen for the post mortem examination. As there is no hospital contract, it is usual practice to contact the funeral director whom the family will be using to arrange transport of the deceased and paperwork. The family will not be liable for any transport costs incurred. A post mortem examination will not usually cause any delay in funeral arrangements, as it will be carried out on the next working day in most cases.

- Authorisation obtained by medical/midwifery staff.
- Mortuary telephoned and informed about the post mortem including a brief outline of the medical history. (Rule out Procurator Fiscal)
- Ward staff should contact the funeral director to inform them that the patient will need transportation to Aberdeen.

- All paperwork including case notes, authorisation and requisition forms should be placed in an envelope and sealed before giving to the funeral director.
- Medical staff should ensure they put a contact number on the requisition form so that they can be telephoned with the provisional findings.
- Normal last office procedures should be followed and the deceased should have an identification bracelet on their wrist or ankle.
- When the funeral director arrives to collect the deceased, he will collect all the paperwork from the ward or a predetermined collection point.
- The mortuary will contact the requesting doctor to relay provisional findings.
- Only part B of cremation papers needs to be completed by requesting doctor **once** the provisional result is known. (Full post mortem only)
- The requesting doctor is responsible for issue of the death certificate not the pathologist.

7.7 Cremation papers



To speed up the completion of all paperwork it is now the practice on the Foresterhill site to complete Part B (the first part) of cremation papers at the same time as the death certificate.

Funeral directors will confirm the need for the papers to be completed by contacting the General Office or the mortuary, who in turn will notify the ward.

- Please make sure the death certificate is completed fully and that the counterfoil is also completed.
- Unless the family have intimated that the deceased is to be buried or a hospital post mortem examination is to be carried out please also complete Part B of the cremation forms.
- Make sure that all questions are answered as fully as possible. **Especially Question 15** where the nursing staff and/or medical staff **must** be named.
- Complete the section pertaining to the Procurator Fiscal, medical devices and implants making sure this section is signed also.
- If there is an implant this requires to be removed, prior to the deceased being released to the funeral directors.
- Place the cremation forms inside the front cover of the patients notes.
- The ward will be notified if the papers need to be completed.
- Cremation forms must be completed within 24 hours of notification.



If you have any queries contact a senior member of medical staff or the anatomical pathology technician who can offer advice. Out of hours the anatomical pathology technician may be contacted on 07759 405648

Section B. To be completed by a doctor with knowledge of the deceased's case and who has seen the body (commonly junior medical staff).

Section C. To be completed by a doctor 5 years post-registration who has seen the body of the deceased. It is good practise for both doctors to be from different wards.

The completed papers must be lodged by the funeral director at the office of the City Council **at least 24 hours** before the time of the cremation.

Avoid delays

Much distress is caused to the relatives by avoidable delays in the completion of these papers. The body of the deceased cannot be released from the hospital mortuary until these papers have been completed. This can lead to the relatives having the body for an unacceptably short period of time before the cremation.

It is essential that these papers are completed without delay and preferably within a maximum of 24 hours of request. On completion the doctor should leave the cremation papers in the mortuary or immediately telephone the General Office who will arrange the uplift of the form and notification of the funeral director. Cremation forms must **NEVER** be sent via the internal mail or given to the family with the Death Certificate. On public holidays and weekends notify mortuary staff.

7.8 Bodies bequeathed to Anatomy, School of Medicine and Dentistry

7.8.1 Procedures to be followed

Effective communication is required to minimise distress and inconvenience when a patient dies who had made arrangements for his/her body to be left to Anatomy for medical education and research.

7.8.2 People who wish to leave their bodies to Anatomy



People who, during their lifetime, express the wish to leave their bodies for medical teaching and research (Anatomy) should contact the Anatomy Bequests Administrator, (Ext 764320 or Tel 01224 274320), Anatomy, School of Medicine and Dentistry, Suttie Centre, Foresterhill, Aberdeen who will discuss the bequest procedure and send the necessary short form for completion and return. Those who are resident outwith the immediate surrounding area would be required to give an assurance that transport costs into Aberdeen would be met from their estates if necessary.

Please note that **only people who have returned completed forms can be accepted by the Department of Anatomy after their death.**

7.8.3 Contacting anatomy staff on the death of someone who has bequeathed his/her body to Anatomy



Death must be certified and a death certificate issued as usual. The doctor certifying death should contact Anatomy, School of Medicine and Dentistry as soon as possible (Ext 764320 or Tel 01224 274320 during office hours 9.00am to 5.00pm, Monday to Friday). At weekends and on Public Holidays if the deceased needs to be moved, ie from a nursing home, then Gordon & Watson, Funeral Directors (01224 580377) may be contacted and will look after the deceased until Anatomy can be contacted. If death takes place in the early hours of the morning, contact should be made as soon as possible after 9.00am that morning. If you have any queries you can seek advice from the anatomical pathology technicians at Foresterhill. In general, a body will be acceptable for use if it is received by Anatomy within 24 to 48 hours of death (see below for situations when it is likely not to be acceptable).

If death is imminent, the Anatomy staff can advise on what to do when death occurs.

If the death occurs in hospital, and the next-of-kin or other relative is there, it would be helpful if medical staff could ask them to stay until a member of the Anatomy staff has been contacted so that the appropriate arrangements can be made without undue delay. If this is not possible, it would be most helpful if a telephone number at which the next-of-kin can be contacted could be obtained and passed to Anatomy staff. This is to allow the exchange of information and completion of necessary registration forms and procedures.

7.8.4 Cases where bodies cannot be accepted for anatomical examination



If the body cannot be accepted for anatomical examination for whatever reason, staff should remind or inform relatives that they will have to make normal funeral arrangements. They may not be anticipating that they will have to do this. Anatomy staff may be able to advise.

- **Post mortem examination**

The situation may arise where the clinician who had final care of a patient who has made a bequest to Anatomy will wish a post mortem to be carried out by the pathology department. If an autopsy has taken place, the body will not be acceptable to Anatomy. This should be clearly explained to the next-of-kin of such patients when making the request for agreement to carry out a post mortem examination. The decision as to whether a post mortem examination takes place, or whether the body is sent to Anatomy, rests with the next-of-kin or whoever holds rights over disposal of the body.

If the case has to be referred to the Procurator Fiscal, please explain to relatives that, if an autopsy is carried out, Anatomy cannot accept the body. If there is no autopsy and the time interval is short, acceptance may be possible.

- **Medical conditions**

The body will also be unacceptable for anatomical examination if the deceased had a recent history of HIV/AIDS, CJD or rapidly progressive dementia, jaundice (ie infective forms of hepatitis, but not obstructive or toxic), tuberculosis or leprosy; severe peripheral vascular disease and/or gangrene; severe contraction deformities; gross obesity; severe muscle wastage/emaciation; certain forms of cancer; recent major surgery. Anatomy staff will advise in such instances.

- **Sufficient bodies**

If at the time of death Anatomy has sufficient bodies for current needs a body will not be accepted.

- **Delays**

It is also unlikely that a bequest will be acceptable if there is undue delay in contacting the Anatomy staff. If more than 24 to 48 hours elapse between death and receipt by Anatomy, it is likely that the body will be unacceptable.

- **Procurator Fiscal**

If the case has been referred to the Procurator Fiscal, it is unlikely that the body would be accepted for anatomical examination.

- **Communication**

Difficulties have very occasionally arisen in the past causing **avoidable distress and inconvenience to relatives** concerning the wishes expressed by the deceased. These have usually arisen as a result of failure of communication between the various parties concerned. This will generally be avoided if the doctor dealing with the death or next of kin contact a member of the Anatomy staff as soon as possible after death has taken place, and if due regard is paid to the situation concerning time delays and post mortem.

7.8.5 Other bequeathed organs



Some patients may have bequeathed organs for other purposes (eg Parkinson's Disease Research. Patients or their relatives or carers should inform staff about this. Procedures after death may have to be done quickly. Seek advice from the anatomical pathology technicians (See Appendix 4)

7.9 Patients' personal property

7.9.1 Return of property

A distressing aspect of bereavement for all parties concerned is the return of belongings when a patient dies in hospital. This should be carried out sensitively, taking into account the individual needs of the relatives. At a time when individuals are upset it seems tactless to ask for a signature on an indemnity form. However, this must not be avoided because it precludes the later possibility of accusations of misuse of patient's property. Some of the distress may be lessened by:

- advising the relatives before the belongings are handed over, that certain policies must be followed which may seem insensitive, but are not intended to be so.
- the person handing over the belongings continuing to be sensitive to the fact that the belongings may have a past significance to the relatives - as a cherished part of the person they have now lost.
- Perishable goods should not be included.
- Jewellery and small items should be placed in a trinket box provided for this purpose.
- Soiled clothing, should be rinsed and placed in a polythene bag. This must be brought to the attention of the relatives.
- Possessions must be packed in the patient's own suitcase/bag or in the carrier bag provided for this purpose by NHS Grampian.
- Supplies of these carrier bags and trinket boxes are held by central stores.

Staff must explain/show that the contents of the labelled hospital carrier bag or suitcase tally with the details on the indemnity form. The relative is requested to sign the indemnity form and this signature is witnessed and signed by two members of staff. The indemnity form should be dealt with according to local procedures.

Death does not restrict itself to office hours. In hospital it is possible that there may be money belonging to the deceased in safe keeping. This should be noted on the indemnity form and the relative's attention drawn to the fact. On the first working day following the death, the nurse in charge must arrange for the return of the money.

7.9.2 Valuables

When it is not possible to return valuables held by the ward to the identified next of kin such property should be sent to the hospital office with the appropriate details. Property, money and valuables may be given to funeral directors, at the request of next-of-kin. This will be signed for when the deceased is collected in the same way jewellery and other personal items that the family request stay with the deceased are signed for.

7.9.3 Unclaimed patients' property

On the rare occasions when patients' property has not been collected, ward staff should contact the next of kin to make arrangements for collection or disposal.

7.9.4 Unwanted belongings

When relatives do not wish to accept certain belongings these must be detailed on the indemnity form.

Unwanted clothing may be cleaned and retained for ward use, given to the Social Work department or added to the emergency clothing cupboard in the Accident and Emergency department. Other unwanted articles should be discarded.

8. Useful telephone numbers



Age Concern Counselling and Advice Service	01224 556463 ext 56463
Anatomy Department	01224 274320 ext 764320
Bereaved Families Support Group	01224 550103 ext 550203
Carers' Centre, 24-28 Belmont Street Aberdeen	01224 646677
Clan Haven (www.clanhouse.org)	01224 630703
Cruse (Bereavement Care)	01224 626199 (Helpline) 01224 626522 (Office)
Donor transplant co-ordinator	Communication Centre
Equality and Diversity Manager	01224 552245
General Office, ARI.	01224 552237 ext 52237
Grampian Police non-emergency number	0845 600-5-700
Hospital Chaplains (See also Appendix 2)	01224 553316 ext 53316
Interpreters	Appendix 3
Macmillan Nurses	
Aberdeen Hospitals	01224 554001 ext 54001
Aberdeen and Aberdeenshire Community Team	01224 557105 ext 57105
Fraserburgh	01346 585274
Peterhead	01779 482568
Banff and Buchan	01261 819182
Elgin	01343 555104
CLIC Sargent Social Worker	01224 552994 ext 52994
Moray Carers Centre 227 High Street, Elgin	01343 450990
Mortuary	Appendix 5
North Aberdeenshire Carers Centres	
5 North Street Peterhead	01779 490894
12 Frithside Street, Fraserburgh	01346 510111
Occupational Health Aberdeen:	01224 553663 ext 53663

Elgin:	01343 667386 ext 67386
Procurator Fiscal, Aberdeen	08445 612650
Procurator Fiscal, Elgin	08445 612670
Others: See Telephone Directory)	
On call weekends & holidays (office hours)	07703 528150
Red Cross House (Bed and Breakfast for relatives outside Aberdeen)	Aberdeen: 01224 592226
Registrar of Births, Deaths & Marriages (Others: See Telephone Directory or Bereavement Pack)	Aberdeen: 01224 276276
Roman Catholic Church	Appendix 2
Samaritans	01224 574488
SANDS (Stillbirth and Neonatal Death Society)	Helpline: 0870 7606649
Scottish Episcopal Church, Church of England	01224 553316 ext 53316 Appendix 2
Social Workers/Care Managers	Appendix 1

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Appendix 1

How to contact a Social Worker/Care Manager

Contact numbers for Social Work in Aberdeen

Aberdeen Royal Infirmary

9.00am - 5.00pm Monday-Thursday and 9.00am – 4.00pm Friday

01224 554383/553510

Aberdeen Maternity Hospital

9.0 am - 5.00pm Monday-Friday

01224 552613/553608

Royal Aberdeen Children's Hospital

8.30am - 5.00pm Monday-Friday

01224 552994/552709

Royal Cornhill Hospital

9.00am - 5.00pm Monday-Thursday

9.00am – 4.00pm Friday

01224 57734/557260

Roxburghe House

8.45am - 5.00pm Monday-Friday

01224 557071

Woodend Hospital

8.30am - 5.00pm Monday-Friday

01224 556401

Dr Gray's Hospital, Elgin

01343 567662

Other hospitals:

Aboyne Hospital	01339 887096
Chalmers Hospital, Banff	01261 818097
Ellon GP Unit	01358 720033
Fleming Hospital, Aberlour	01542 886174
Fraserburgh Hospital	01346 513281
Glen O'Dee Hospital, Banchory	01330 824991
Insch Hospital	01466 794488
Inverurie Community Hospital	01467 628030
Jubilee Hospital, Huntly	01466 794488
Kincardine Community Hospital, Stonehaven	01569 763800
Peterhead Community Hospital	01779 477333
Seafeld Hospital, Buckie	01542 837200
Stephen Hospital, Dufftown	01542 886174
Spynie Hospital	01343 557222
Turriff Hospital	01888 562427
Turner Memorial Hospital, Keith	01542 886174

Outwith normal working hours:

If a social worker/care manager is required outwith the above times contact should be made with the Social Work **Out-of-Hours Service**:

Aberdeen City	01224 693936
Aberdeenshire North, Central and South	0845 8400070
Moray	0845 7565656

Integrated health and social care teams

Community social workers/care managers are available within the integrated health and social care team at General Practitioner surgeries and can provide support. The Duty Community Social Worker/Care manager can be contacted Mon – Thurs 9.00am - 5.00pm & Fri 9.00am - 4.00pm on 01224 264004.

Appendix 2

How to contact a hospital chaplain

Aberdeen hospitals

A team of chaplains provides religious, spiritual and pastoral care for the hospitals in Aberdeen. During office hours you can contact the chaplains on the following numbers.

Chaplains' Office, Aberdeen Royal Infirmary	01224 553316
Chaplains' Office, Roxburghe House	01224 557077
Chaplains' Office, Royal Aberdeen Children's Hospital	01224 554905
Chaplains' Office, Royal Cornhill Hospital	01224 557293
Chaplains' Office, Woodend Hospital	01224 556788

Out of hours for Royal Cornhill Hospital	
Contact Central Reception	01224 557201

Out of Hours for **other Aberdeen Hospitals** Contact the NHS Grampian Communication Centre 0845 456 6000 and ask them to page the on-call chaplain

See below for arrangements for calling a Roman Catholic Chaplain

Hospitals outside Aberdeen

Part time chaplains currently serve hospitals outside Aberdeen. Individual hospitals have contact information for their hospital chaplains.

You may also contact the Aberdeen Chaplains for advice.

01224 553316 Ext 53316

The Communications Centre will help if you have difficulty contacting a chaplain.

Episcopal, Anglican or Church of England patients

The Scottish Episcopal Chaplaincy Team, covering all Aberdeen Hospitals.
Contact:

The Chaplains' Office, Aberdeen Royal Infirmary 01224 553316 Ext 53316

If in difficulty out of hours, contact the NHS Grampian Communication Centre 0845 456 6000 and ask them to page the on-call chaplain.

Roman Catholic patients

In Aberdeen during office hours

Aberdeen Maternity Hospital, Aberdeen Royal Infirmary, Roxburghe House and Royal Aberdeen Children's Hospital

Contact Chaplains' Office, ARI: 01224 553316 Ext 53316

Royal Cornhill Hospital

Contact Chaplains' Office, Royal Cornhill Hospital 01224 557293 Ext 57293

Woodend Hospital

Contact Chaplains' Office, Woodend Hospital: 01224 556788 Ext 56788

Out of hours and in emergencies

Contact the NHS Grampian Communication Centre 0845 456 6000 and ask them to page the Roman Catholic Chaplain

Hospitals outside Aberdeen

Local hospitals will have contact information for hospital chaplains

Appendix 3

1. Language interpretation within NHS Grampian

“Interpretation” is defined as changing the spoken word from one language to another. If a patient, their relatives or friends do not speak English, consideration must be given to how their interpretation needs can best be met. First, try to establish which language they speak. Then, there are three main options.

a) Using a friend or a relative to interpret

It could be that the patient is accompanied by a friend or relative who may be able to act as an interpreter. If appropriate, the friend or relative might be used to interpret, however, consideration must be given to the circumstances and any sensitivity involved. In addition, there can be no guarantee that the friend or relative has the ability to interpret accurately. It is not appropriate to use a child as an interpreter, except in circumstances of extreme urgency when there is no viable alternative.

b) Face to face interpreter services

We have a pool of 120 experienced and qualified face to face interpreters available to us, offering a range of 60 different languages, in all areas of Grampian. **The contact arrangements are:**

For the acute sector during working hours, contact Administration on extension 53674 or 54150. In an out of hours emergency situation, **you can contact Grampian Police on 0845 600 5 700 and ask for the Information Room.**

For Moray during office hours, contact local management on extension 67202 or 67349. Outwith office hours, the Accident and Emergency Department hold a list of interpreters who have agreed to make themselves available at short notice.

For primary care, please refer to your local arrangements.

In an emergency situation, if you are unable to access any of the usual arrangements, you can contact Grampian Police on 0845 600 5 700 and ask for the Information Room.

c) Language Line

Language Line is a telephone based interpretation service. It gives staff access to expert interpreters, on the telephone, in 60 to 90 seconds, for over 170 different languages. Within NHS Grampian, there are over 600 Access Points. Every hospital, GP practice, clinic and outpatient department in Grampian is equipped. There are also staff trained in its use in each location. In addition, each Access Kit contains full instructions on how to access the service.

If you require a Language Line Access Kit for your area, contact the Equality and Diversity Manager on extension 52245 or by email at: nigel.firth@nhs.net. There are also mobile access kits for use in a patient's home, where there is no fixed land line.

2. British Sign Language (BSL) Signers

BSL signers can be accessed through the Administration Department at ARI (extension 53674, or email michelle.harrows@nhs.net).

3. Deaf Blind communicators

Deaf blind communicators are accessed via DeafBlind Scotland, who are based at Lenzie near Glasgow. Accordingly, it is important to book a communicator well in advance, if possible. DeafBlind Scotland can be contacted on 0141 777 6111 or 0141 775 3311 or by email at: info@deafblindscotland.org.uk

4. Portable Induction Loops (PILs)

Portable Induction Loops (PILs) are a great help to anyone who uses a hearing aid. The PIL amplifies speech and transmits it direct to a hearing aid. There are over 200 PILs in use in Wards, Outpatient Departments and Clinics. If you require a PIL, contact the Equality and Diversity Assistant on extension 51116 or by email at: Roda.bird@nhs.net. The training on how to use a PIL takes 10 minutes.

5. Translated material

"Translation" is defined as changing the written word from one language to another. If required, written information can be translated into any other language or format, on request. This usually takes 5 working days. This can be done by contacting the Equality and Diversity Manager on extension 52245, or by email at nigel.firth@nhs.net. There is also a large volume of NHS Grampian health care information which is pre-translated. In addition, the Equality and Diversity Manager will check other NHS sources to see what information is already available in translation.



6. Material in Braille and large print

Material can be put into Braille or large print format by contacting the Equality and Diversity Manager on extension 52245 or by email at: nigel.firth@nhs.net. It usually takes 2 to 3 working days.

Appendix 4

How to contact the on-call anatomical pathology technician, Foresterhill site (mortuary staff)

The mortuary telephone number is 01224 552112 Ext 52112

The normal working hours of the anatomical pathology technicians (APTs) are:

Monday - Friday	8am - 5pm
Saturday	8am - 1pm

One of the anatomical pathology technicians is on call at all times out with these hours either to give advice or to come in as necessary. Some of the reasons hospital staff may call on the services of the anatomical pathology technicians out with the above hours are:

1. When relatives of the deceased person wish to view the body.
2. When police wish to remove the body from the mortuary.
3. When a funeral director has travelled from a considerable distance and cannot arrive within normal working hours.
4. When the body of a deceased person is to be donated to Anatomy department.
5. When the deceased person's corneas are to be donated.
6. When information about post mortem procedures is required.
7. When a member of medical staff urgently needs to complete either a death certificate or cremation papers.

Procedure:

1. Contact the on-call anatomical pathology technician either directly by telephoning 07759 405648, or via communication centre. Please note that this is a mobile phone and if the APT is already in the hospital the telephone may be switched off for a short period of time.
2. Have the following information available to relay to the anatomical pathology technician.
 - Name of the deceased person
 - Address of the deceased person
 - Hospital unit number of the deceased person
 - Hospital
 - Ward number or name
 - Purpose of the call out
3. As it is likely that the anatomical pathology technician will not be on the Foresterhill site please allow for travelling time if they have to come in. If the deceased is to be viewed time also needs to be allowed for preparation of the body.

Remember

The relatives of the deceased person should be escorted to the mortuary viewing area either by a member of nursing staff or, if that is not possible, one of the hospital chaplains.

Appendix 5

“Death and the Procurator Fiscal”

Information and Guidance for Medical Practitioners
Produced by Crown Office and Procurator Fiscal Service October 2008

Contents

1. Introduction
2. Who is the Procurator Fiscal?
3. Timescale for reporting to the Procurator Fiscal
4. To which Procurator Fiscal should the death be reported?
5. Who should report the death?
6. Categories of deaths to be reported
7. What does the Procurator Fiscal require to know?
8. What action will the Procurator Fiscal take?
9. Deaths associated with medical or dental care
10. Control of the body, cremation etc
11. Post mortem examination
12. Hospital post mortems
13. Asbestosis, mesothelioma and asbestos-related lung cancer
14. Deaths where there is a possibility of criminal proceedings
15. Organ transplantation
16. Retention of organs following post mortem examination – Human Tissue (Scotland) Act 2006
17. Persistent vegetative state, withdrawal of life support facilities
18. Medical personnel as witnesses

- Annex 1 List of Area Deaths Units and local Procurator Fiscal Offices which receive death reports
- Annex 2 Sample Form F89
- Annex 3 Reporting Checklist

1. Introduction

The Crown Office and Procurator Fiscal Service (COPFS) has produced this booklet for the information and guidance of medical practitioners. The booklet is intended to provide a clear, concise guide and to assist medical practitioners to decide whether a death requires to be reported to the Procurator Fiscal and, if so, how to go about doing this.

2. Who is the Procurator Fiscal?

The Procurator Fiscal is a lawyer employed within the Crown Office and Procurator Fiscal Service which is part of the Scottish Government. The Procurator Fiscal's best known role is as the local public prosecutor but he or she has a separate duty to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths and any deaths occurring in circumstances causing serious public concern. The Procurator Fiscal's right and duty to investigate such deaths derives from Scottish Common Law (i.e. custom and practice which has developed over the centuries and now has the force of law) and it is reinforced by the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Although there are many significant differences there are some similarities between the roles of the Procurator Fiscal in Scotland and the Coroner in England and Wales.

The Crown Office and Procurator Fiscal Service divides Scotland into 11 geographical areas each headed by an Area Procurator Fiscal. With the exception of Glasgow which is an Area in its own right, each Area contains a number of District Offices each headed by a District Procurator Fiscal. District Offices usually have one or more Procurator Fiscal Deputies who can exercise all the powers of the Procurator Fiscal.

3. Timescale for reporting to the Procurator Fiscal

All reportable deaths must be notified to the Procurator Fiscal as soon as possible after occurrence and **before any steps are taken to issue a death certificate**. If a death certificate has been issued and the Procurator Fiscal declines to accept the cause of death, the certificate will have to be retrieved from the family, a self evidently distressing procedure which should be avoided as far as possible.

The Procurator Fiscal will normally deal with reports of deaths during office hours. In situations of urgency, and particularly if the death is suspicious or if there are religious rites which require to be observed, each District or Area has an out of hours on-call service which can be contacted through the police. It is stressed, however, that **this facility should only be used where the matter cannot wait until the next working day.**

4. To which Procurator Fiscal should the death be reported?

Responsibility for investigating a death rests with the Procurator in whose jurisdiction the accident or other event which caused the death occurred. This will not necessarily be the same as the place of death. For example if a person is injured in a fire in Dunfermline and taken to the Burns Unit in Livingston where he dies of his injuries, the death should be reported to the Procurator Fiscal in Dunfermline. Similarly, if a person is injured in a climbing accident in Glencoe and taken to the Southern General Hospital in Glasgow where she dies of her injuries, the death should be reported to the Procurator Fiscal in Fort William.

Certain COPFS Areas have established centralised deaths units while others retain the previous system of reporting to individual offices. **Annex 1 contains a list of the current reporting points for deaths throughout Scotland.**

If a medical practitioner is in doubt about where a death should be reported he or she should seek advice from the Procurator Fiscal in whose jurisdiction the death occurred.

5. Who should report the death?

The death should be reported by the doctor with the best knowledge of the circumstances. This will vary from case to case but the essential points are that the reporting doctor must understand clearly why the death is being reported and must be able to answer any questions which the Procurator Fiscal may ask.

6. Categories of deaths to be reported

The following deaths **must** be reported to the Procurator Fiscal.

(i) **Sudden deaths**

- (a) any death where there is evidence or suspicion of homicide;
- (b) any death by drowning;
- (c) any death by burning or scalding or as a result of fire or explosion;
- (d) any death caused by an accident involving the use of a vehicle including an aircraft, a ship or a train;
- (e) any death resulting from an accident in the course of work, including voluntary or charitable work;
- (f) any death where the circumstances indicate the possibility of suicide;
- (g) any death following an abortion or attempted abortion whether legal or illegal;
- (h) any death of a person subject to legal custody, including any death of such a person outwith a Police station or prison (for example during prisoner transport or in hospital);
- (i) any death occurring in health premises in the community including a GP's surgery, health centre, dental surgery or similar facility;

- (j) any death due to violent, suspicious or unexplained circumstances.
- (ii) **Deaths related to neglect or complaint**
- (a) any death where the circumstances seem to indicate fault or neglect on the part of another person;
 - (b) any death, if not already reported, where a complaint is received by a Health Board or NHS Trust and the complaint is about the medical treatment given to the deceased with a suggestion that the medical treatment may have contributed to the death of the patient.
- (iii) **Deaths of children**
- (a) any death of a newborn child whose body is found;
 - (b) any death which may be characterized as sudden unexplained death in infancy (SUDI) or the like;
 - (c) any death of a child from suffocation including overlaying;
 - (d) any death of a child in foster care;
 - (e) any death of a child in the care of a Local Authority;
 - (f) any death of a child on a Local Authority "at risk" register.
- (iv) **Public Health**
- (a) any death caused by an industrial disease or industrial poisoning;
 - (b) any death due to a disease, infectious disease or syndrome which poses an acute, serious public health risk including:
 - any form of food poisoning
 - Hepatitis A, Hepatitis B (with or without delta-agent co-infection (Hepatitis D)), Hepatitis C and Hepatitis E
 - any hospital acquired infection
 - Legionnaires Disease
- (v) **Deaths associated with medical or dental care (see also Section 9 below)**
- (a) any death which was unexpected having regard to the clinical condition of the deceased prior to his or her receiving medical care;
 - (b) any death which is clinically unexplained;
 - (c) any death which appears to be attributable to a therapeutic or diagnostic hazard;

- (d) any death which is apparently associated with lack of medical care;
- (e) any death which occurs during the administration of a general or local anaesthetic;
- (f) any death which may be associated with the administration of an anaesthetic;
- (g) any death caused by the withdrawal of life sustaining treatment to a patient in a persistent vegetative state (This is to be distinguished from the removal from a life-support machine of a person who is brain stem dead and cannot breathe unaided.) (See also **Section 17** below);
- (h) any death occurring as a result directly or indirectly of an infection acquired while under medical or dental care while on NHS premises, including hospitals, GP's surgeries, health centres and dental surgeries.

These categories should not be regarded as exhaustive.

- (vi) Any drug-related death (This category includes death as a result of ingestion of any drug where the death does not fall into any category above.)
- (vii) Any death not falling into any of the foregoing categories where the cause remains uncertified or where the circumstances of the death may cause public anxiety.

If there is any uncertainty about whether a death should be reported the matter should be discussed with the Procurator Fiscal **before** any steps are taken to issue a death certificate.

In some areas there is a practice of reporting to the Procurator Fiscal deaths which occur within 24 hours of admission to hospital. This appears to be based on English practice and is not necessary unless the death falls into one of the reportable categories set out above.

7. What does the Procurator Fiscal require to know?

When reporting a death to the Procurator Fiscal the medical practitioner must have the relevant case notes in front of him or her and must be in a position to answer any questions which the Procurator Fiscal may ask.

In all cases the following information should be available

- Name of deceased
- Age and/or date of birth
- Home address
- Religion/ethnic origin

- Place, date and time of death
- Nearest relatives (if known) and whether they have any special needs e.g. translation
- General Practitioner (if known)
- History (see further below)
- Cause of death, if ascertained, and whether the death can be certified
- The name of the doctor who proposes to sign any death certificate
- Whether the family have any concerns about the circumstances of the death

The history provided to the Procurator Fiscal will depend on the medical history of the deceased and the circumstances of the death. Broadly, however, what is required is sufficient information to enable the Procurator Fiscal to decide whether it is appropriate to accept any death certificate which may be offered or whether to initiate further action, for example by instructing the police to investigate and report. The history will also assist the Procurator Fiscal to decide whether to instruct a post mortem examination. **Annex 3** provides a checklist for reporting deaths to the Procurator Fiscal.

8. What action will the Procurator Fiscal take?

This will depend on the details of the individual case and the following examples are for illustration only.

Take no further action. This is likely to be the decision if the doctor reporting the death is prepared to issue a Death Certificate and the Procurator Fiscal is satisfied from the history reported that the death occurred from natural causes and does not require further investigation.

Request a police report. Where the cause of death has not been ascertained or the Procurator Fiscal requires further information a police report is likely to be requested. **The requesting of a police report does not mean that the Procurator Fiscal regards the matter as criminal.** In such a situation the police are acting as the agents of the Procurator Fiscal and gathering information on his or her behalf. The Procurator Fiscal will almost always instruct a police report in a case where he or she anticipates instructing a post mortem examination.

Consent to a hospital (non-PF) post mortem examination. Occasionally where the cause of death has not been certified, a hospital doctor will inform the Procurator Fiscal that the hospital has received permission from the relatives to carry out a post mortem examination. If the death does not otherwise require investigation the Procurator Fiscal will normally permit the hospital post mortem to proceed, subject to being advised of the cause of death. See also **Section 12** below.

9. Deaths associated with medical or dental care

Certain deaths associated with the provision of medical care must be reported to the Procurator Fiscal. Most deaths under medical care represent an unfortunate outcome where every reasonable care has been taken. However, such deaths may involve negligence on the part of medical or para-medical staff, may give rise to questions of public safety and may even be associated with criminality.

Deaths associated with medical care include deaths which may be due to medication (however administered) or diagnostic or therapeutic procedures (operations, investigations, X-ray procedures, etc). "Medical care" should be interpreted broadly and includes surgical, anaesthetic, nursing or any other kind of medical care whether being given in a hospital, a GP's surgery, the patient's home or elsewhere. It also includes deaths from "hospital acquired" infections.

Where a death is associated with medical care, no steps should be taken to issue a death certificate until the Procurator Fiscal has confirmed that he or she does not require post mortem examination.

Medical practitioners are reminded that Scottish Government has informed Health Boards and Trusts that where a complaint is received concerning the medical treatment given to the deceased, suggesting that the medical treatment may have contributed to the death, the Procurator Fiscal should be notified. If the death has not already been reported to the Procurator Fiscal this should be done in tandem with notification of the complaint.

The initial report to the Procurator Fiscal should be made by telephone as soon as possible after the death. In addition to providing the information specified in the previous section, the doctor reporting the death should complete Form F.89 (see **Annex 2**) and forward this to the Procurator Fiscal electronically or by fax without delay. The doctor completing the Form F.89 should consult with other doctors involved in the case, as required, to ensure that the information in the form is full and accurate and to establish whether there is any matter which should be brought to the attention of the Procurator Fiscal. This is likely to be particularly important where the deceased has died following surgery.

On receipt of the Form F.89, the Procurator Fiscal will consider whether it is necessary to request the doctor in charge of the case and, where appropriate, other doctors who have been involved in the treatment or investigation of the patient to provide a full written report detailing the circumstances leading up to and surrounding the death.

The Procurator Fiscal may decide not to enquire further where he or she is satisfied that negligence and criminality have been excluded. The decision whether a post mortem examination is necessary will be taken by the Procurator Fiscal. In many cases, the need for further inquiries and the direction of such inquiries will be informed by the post mortem examination findings and may involve obtaining a report from an independent expert in the relevant field - medical, pharmaceutical, scientific or as appropriate. Such an independent

expert may wish to discuss the circumstances with the doctor(s) involved in the treatment of the deceased.

Similar principles should apply to any death in the course of dental treatment.

10. Control of the body, cremation etc

When a death is reported to the Procurator Fiscal, he or she acquires the right and duty to control the disposal of the deceased's body while making enquiries into the death. This may require the removal of the deceased's body to a police or hospital mortuary or a specially designated mortuary. The Procurator Fiscal must decide in every case whether to accept any death certificate which may be offered and release the deceased's body or whether to instruct a post mortem examination. When the Procurator Fiscal decides to release the deceased's body, he or she must also decide whether to permit cremation. In the vast majority of cases there will be no objection to cremation but there may be circumstances where the Procurator Fiscal cannot allow cremation to take place, as it will lead to the destruction of evidence available from the deceased's body.

11. Post mortem examination

If no medical practitioner is able to certify the cause of death or, more rarely, if the Procurator Fiscal is not prepared to accept a certificate which is offered, a post mortem examination will usually be required to ascertain the cause of death. Forensic pathology arrangements are regulated by contracts between COPFS and those providing forensic pathology services, generally the universities. It is a matter for the Procurator Fiscal to decide whether there should be a post mortem examination, the nature and extent of that examination and the individual to conduct it. In some cases, however, it is possible for the cause of death to be confirmed by a doctor who has viewed the deceased and is able to grant a certificate certifying the cause of death without the need for a full post-mortem examination to be undertaken. This is described as 'view and grant'. However, where a post mortem examination is necessary for the full and proper investigation of the death, the Procurator Fiscal's right to instruct this may have to override religious or other objections.

12. Hospital post mortems

If the deceased has died in hospital and the Procurator decides that the death does not require any further action or investigation, the question of a post mortem examination to establish the cause of death is a matter for the hospital.

Similarly, the Procurator Fiscal is sometimes asked by hospital doctors to permit a post mortem examination in the interest of medical research or for some other medical reason although the cause or primary cause of death is known. In cases where the cause of death has been ascertained without a dissection and the Procurator Fiscal does not otherwise require a post mortem examination to be held, it would not be appropriate for him or her to instruct one. In such cases the matter is between the hospital and the nearest relatives.

If a hospital post mortem examination reveals suspicious circumstances or other cause for concern, it should be halted immediately and the Procurator Fiscal informed.

13. Asbestosis, mesothelioma and asbestos-related lung cancer

A number of industrial diseases, including the above, can be accurately diagnosed in life and it may be possible to accept the cause of death certified without a post mortem examination.

A combination of radiological evidence and an ante-mortem pleural biopsy with histological examination using immunohistochemical staining techniques (e.g. positivity for Calretinin, CK 5/6, EMA, Vimentin) may conclusively diagnose Mesothelioma and may be sufficient to allow settlement of a compensation claim.

If a conclusive diagnosis is not obtained during the patient's life, the Procurator Fiscal will require to instruct a post mortem examination to establish the cause of death and to preserve the necessary evidence in the event that the nearest relatives wish to pursue a civil action in relation to the deceased's exposure to asbestos.

14. Deaths where there is a possibility of criminal proceedings

Criminal proceedings may follow a death in a variety of circumstances. The most obvious example is homicide but criminal proceedings may follow from a road traffic death, an overdose of controlled drugs, an accident at work or a contravention of food safety legislation. These are only examples and not an exhaustive list.

In any case where it will be necessary to prove the fact and cause of death in subsequent court proceedings, the Procurator will instruct a post mortem examination by two pathologists. This may be two forensic pathologists or it may be a forensic pathologist and a specialised pathologist, for example a paediatric pathologist if the death is that of a child.

In addition to the post mortem examination, the Procurator Fiscal may instruct further scientific investigation, for example by toxicology. The need for this may be self evident or may be identified by the pathologists in the course of the autopsy.

Medical personnel, particularly hospital medical staff, who have treated a patient whose death becomes the subject of criminal proceedings, may find themselves becoming witnesses. (See also **Section 18** below).

In a case which is likely to give rise to criminal proceedings, it is necessary for there to be corroborated evidence of the identity of the deceased. In most cases this will be provided by relatives or police officers but sometimes hospital staff are required to provide a link in a chain of identification evidence.

15. Organ transplantation

A Protocol has been drawn up between COPFS and the Scottish Transplant Group with regard to organ and tissue donation. A detailed discussion is outwith the scope of this document but the most important points are:-

- where there is reason to believe that the death may be reported to the Procurator Fiscal, no parts of a body will be removed without his or her prior consent;
- the Procurator Fiscal may object to removal of organs in a case which is likely to result in a charge of murder or where, in the time available, insufficient enquiry is able to be carried out to allow an informed decision. There are procedures available which will allow the Procurator Fiscal not to object to transplantation of organs in cases of murder but early discussion with the PF is essential;
- the Procurator Fiscal will normally permit removal of organs subject to the need to ensure that sufficient evidence is available for any subsequent criminal proceedings or Fatal Accident Inquiry and the need to establish that the death has not been caused or contributed to by the retrieval operation.

16. Retention of organs following post mortem examination - Human Tissue (Scotland) Act 2006

The Human Tissue (Scotland) Act 2006 came into force on 1 September 2006. Detailed discussion of the Act is outwith the scope of this document but the Act was driven largely by public concern over the practice of organ retention, and is intended to inspire confidence by introducing the need for authorisation for the removal, transplantation or retention of organs and tissue. Authorisation means that people can authorise what is to happen to their organs after their death. If the deceased expressed no views in life about this matter, the Act lists a hierarchy of nearest relatives from whom authorisation can be sought. It is a positive concept which replaces the 'lack of objection' approach of the Human Tissue Act 1961. The authorisation arrangements set out in the Act apply in the transplantation and hospital post-mortem examination contexts and have 3 categories:

- adults (those aged 16 or over who have the capacity to make their own decisions about these matters);
- children aged 12 or over at the time of their death;
- children aged under 12 at the time of their death.

It should be noted that **the Act does not affect the instruction or mechanics of Procurator Fiscal post mortem examinations**. Where a sudden, unexplained, unexpected or suspicious death has been reported to the Procurator Fiscal, the decision to carry out a post mortem examination to ascertain the cause of death remains with the Procurator Fiscal. The Act does govern what should be done with organs and tissue samples that have been removed in the course of that post mortem examination once the Procurator Fiscal's purposes have been served.

17. Persistent vegetative state, withdrawal of life support facilities

The case of *Law Hospital NHS Trust v Lord Advocate 1996 SLT 848* explains what should happen when a Health Board or NHS Trust which has care of a patient, or any relative of a patient, seeks the withdrawal of treatment. This should normally be done by an application to the Court of Session requesting the exercise of the *parens patriae* jurisdiction. However, in the *Law Hospital* case, the court decided it was not necessary to require such an application in every case and that the decision whether an application is necessary must rest with those who will be responsible for the withdrawal of treatment. Due regard must be given to the views of the patient's relatives.

Following this decision the Lord Advocate announced the approach that will be adopted by the Crown when life sustaining treatment or medical treatment is withdrawn or discontinued for patients who are incapable of consenting to such withdrawal or discontinuation. The Lord Advocate will not authorise the prosecution of a qualified medical practitioner (or any person acting upon the instruction of such a practitioner) who, acting in good faith and with the authority of the Court of Session, withdraws, or otherwise causes to be discontinued, life sustaining treatment or other medical treatment from a patient in a persistent, or permanent vegetative state (PVS), with the result that the patient dies.

It will be noted from the terms of the Lord Advocate's statement that immunity from prosecution does not automatically extend to medical practitioners who have not sought and received the authority of the Court. The Lord Advocate has expressed the view, however, that if doctors and those acting on their instructions were acting in accordance with accepted medical practice and had exercised the proper degree of care expected of them, it would be very unlikely that any prosecution in the public interest would be brought against them.

Any death following the withdrawal of life support facilities (whether with or without the authority of the Court of Session) must be reported to the Procurator Fiscal as soon as it occurs. Under certain circumstances the Procurator Fiscal may require to instruct an autopsy, although each case will be considered on its individual circumstances.

18. Medical personnel as witnesses

From time to time it may be necessary for medical or nursing staff who have treated a deceased patient to give evidence in court. This may be in criminal proceedings or in a Fatal Accident Inquiry.

In more serious cases medical staff may be cited to attend at the Procurator Fiscal's office to give a pre-court statement known as a "precognition." Precognition is an important part of the criminal process. Procurators Fiscal will normally be willing to be flexible in order to accommodate professional commitments.

In many cases the medical evidence will be capable of agreement and it will be unnecessary for doctors or nurses actually to give evidence. On the other hand

medical evidence may be controversial or may be of such crucial importance to the case that personal attendance as a witness is unavoidable. In such a situation the Procurator Fiscal will normally be willing to enter into a "standby" arrangement with the witness. The details of such an arrangement will necessarily vary depending on the circumstances of the case, geography etc. but in broad terms the witness will be permitted to go about his/her normal duties and will be called to court by a telephone call giving an agreed period of notice. **It is stressed that the responsibility for initiating such an arrangement rests with the witness** who should contact the appropriate Procurator Fiscal immediately on receipt of the witness citation. Procurators Fiscal will do everything possible to accommodate reasonable professional commitments but a witness does not have a right to a standby arrangement and this may not always be possible.

It is a criminal offence for a witness to fail to attend court in terms of a citation unless he or she has been excused by the Procurator Fiscal or has another lawful reason for non-attendance.

Annex 1

List of area deaths units and local offices which receive death reports (as at October 2008)

Argyll and Clyde

District Fiscal's Office:

- Paisley 0844 561 3324
- Campbeltown 0844 561 4525
- Dumbarton 0844 561 3446
- Dunoon 01369 70 2292
- Oban 0844 561 4520
- Greenock/Rothesay 0844 561 3404

Ayrshire Area

District Fiscal's Office:

- Kilmarnock 0844 561 2701
- Ayr 0844 561 2747

Central Area

District Fiscal's Office:

- Stirling 0844 561 3110
- Alloa 0844 561 3110
- Falkirk 0844 561 3110

Dumfries and Galloway Area

District Fiscal's Office:

- Dumfries 0844 561 3620
- Stranraer 0844 561 3630

Fife Area

District Fiscal's Office:

- Kirkcaldy 0844 561 3510
- Cupar 0844 561 3565
- Dunfermline 0844 561 3550

Glasgow Area

District Fiscal's Office:

- Glasgow 0844 561 2220

Grampian Area

District Fiscal's Office:

- Aberdeen 0844 561 2650
- Banff 0844 561 2660
- Elgin 0844 561 2670
- Peterhead 0844 561 2680
- Stonehaven (Part time staffed, contact Aberdeen)

Highlands and Islands Area

District Fiscal's Office:

- Inverness 0844 561 2925
- Dingwall 0844 561 2976
- Fort William 01397 70 3874
- Kirkwall 01856 87 3273
- Lerwick 01595 69 2808
- Lochmaddy 0844 561 3014
- Portree 01478 61 2510
- Stornoway 0844 561 4470
- Tain 0844 561 2994
- Wick 0844 561 2989

Lanarkshire Area

District Fiscal's Office:

- Hamilton 0844 561 3245
- Airdrie 0844 561 3246
- Lanark 0844 561 3285

Lothian and Borders Area

District Fiscal's Office:

- Edinburgh 0844 561 3875
- Duns (Part time staffed, contact Selkirk or Jedburgh)
- Haddington 0844 561 4225
- Jedburgh 0844 561 4295
- Linlithgow 0844 561 4240
- Selkirk 0844 561 4301

Tayside Area

District Fiscal's Office:

- Dundee 0844 561 2870
- Arbroath 0844 561 2920
- Forfar 0844 561 4450
- Perth 0844 561 2910

Annex 2

F.89

CONFIDENTIAL

DEATH UNDER MEDICAL CARE
(see Note 1)

To the Procurator Fiscal

.....

1. Report on the Death of:
Full name Date of Birth
- Home Address
(block capitals)
2. Date and Time of Death
- Place of Death (specifying exact location)
-
- Date of admission to hospital (if applicable)
3. Nature of Disease, Injury or Condition for which medical care was advised.
4. Brief description of clinical findings prior to the procedure, including details of any concurrent pathology.
5. Brief description of medical treatment and preparation of the patient for the procedure. (Please include all medications, doses and times, excluding pre-medication and anaesthetic agents, see para. 9),
6. Was consent obtained for the procedure?
7. PROCEDURE
(a) Was the procedure elective or emergency?
- (b) Nature of procedure (indicate whether proposed, performed, or in progress)
-
- (c) Date and Time: Started: Finished
- (d) Operator (or doctor involved)
- (e) Comments: (block capitals)
8. Was anaesthesia employed (local, regional or general)?
.....

9. If so, please give details:
- (a) Pre-medication
 - (b) Type of anaesthesia
 - (c) Date and time administration started
 - stopped
 - (d) Details of agents and techniques used, including quantities
 -
 -
 - (e) Anaesthetist
 - (block capitals)
 - (f) Comments:

10. Details in chronological order of events immediately preceding death and of resuscitative measures undertaken.

11. Opinion as to cause of death, and any other general observations on the case.

Date Signature (doctor concerned)

(designation)

Signature (doctor concerned)

(designation)

NOTES: 1. Deaths to be reported:—

- (a) Cases to be reported would include deaths associated with medication and deaths occurring during or immediately after diagnostic or therapeutic procedures including surgical operations whether anaesthesia was employed or not.
 - (b) Deaths which occur in the immediate post-operative period ordinarily not exceeding 12 hours following a general anaesthetic from which consciousness has not been regained.
- 2. Wherever practicable this form should be completed in consultation with any other Medical Practitioner specially concerned or specifically mentioned and forwarded to the Procurator Fiscal as soon as possible.
 - 3. The Death Certificate must not be issued until instructions have been received from the Procurator Fiscal or his representative.
 - 4. The completion of Question 11 is a matter of discretion. It is to assist the Procurator Fiscal and his Medical Adviser to arrive at a certifiable cause of death.

Annex 3

Reporting checklist

1. Check whether you are required to report the death to the Procurator Fiscal and be sure you understand why the death is being reported. **If you are in any doubt about the need to report, consult the Procurator Fiscal before issuing a Death Certificate.**
2. Check where the accident or other event which caused the death occurred.
3. Refer to Annex 1 of this document to identify the appropriate Procurator Fiscal to receive the report (if in doubt consult your local Procurator Fiscal).
4. Before telephoning the Procurator Fiscal check that you have the following information to hand:
 - Name of deceased
 - Age and/or date of birth
 - Home address
 - Religion/ethnic origin
 - Place, date and time of death
 - Nearest relatives (if known) and whether they have any special needs e.g. translation
 - General Practitioner (if known)
 - History
 - Cause of death if ascertained and whether the death can be certified
 - The name of the doctor who proposes to sign any death certificate
 - Whether the family have any concerns about the circumstances of the death
5. If the death is associated with medical care, complete Form F89 and forward it by fax or email to the Procurator Fiscal.

Appendix 6

Procedures for last offices for patients who died in the hospital setting

(2 December 2010)

Introduction

Definition:

Last offices is the care given to a deceased patient which demonstrates our respect for the dead and is focused on fulfilling religious and cultural beliefs as well as health and safety and legal requirements (Dougherty & Lister 2008 – 7th edition). The Royal Marsden Manual of Clinical Nursing Procedures

This procedure is a set of detailed step by step instructions that describe the appropriate method of carrying out last offices to achieve the highest standards possible to ensure efficiency, consistency and safety.

Patient care does not finish when the patient dies (Hill 1997). Administering last offices can be a fulfilling experience as it is the final demonstration of respectful, sensitive care given to a patient (Nearney 1998). Undertaking last offices also gives the message to the family and other patients that caring continues after death (Speck 1992).

This procedure has been drawn up by a short life working group to assist staff in providing the final nursing care to a patient after death has been verified.

Members of short life working group:

Anne Cargill, Group Nurse Manager
Allan Leslie, Professional Development Facilitator
Jane Ewen, Ward Sister, Ward 18 Woodend
Helen Mellis, Sister, A&E, Dr Gray's Hospital
Margaret Ritchie, Neuro-oncology nurse

Important points

1. Last Offices should only be carried *out* following certification of death by medical staff and recording of confirmation of death in patient's medical and nursing notes.
2. Last Offices should be carried out in an unhurried manner, preserving the dignity of the patient at all times.
3. Staff should recognise the impact a death may have on other patients.
4. Patient's religion must be checked to conform with religious customs.

5. Staff should ensure that all administration tasks are carried out.
6. Pacemakers and other implants should be removed according to local policy. Special arrangements are required for Internal Cardioverter Devices (ICD) and staff should be aware of the local policy for deactivation and removal. Where possible the ICD should be deactivated before last offices are carried out. If necessary advice should be sought from the Cardiac Department.
7. Plaster of Paris should not be removed.
8. Notification of death to the Procurator Fiscal may be required in some instances. Check with medical staff.
9. If a patient has a known risk of infection please refer to 'Care of Deceased Patients with a known risk of infection'. (Intranet – Infection Control - Policy for the Isolation of Patients within the NHS Hospital Setting with a Known or Suspected Transmissible Infection). This should be considered prior to commencement of last offices and Standard Infection Control Precautions (SICPs) must be applied while handling the body.
http://intranet.grampian.scot.nhs.uk/foi/files/Isolation_Policy_Nov_2009.doc
10. In cases of all deaths reported to the Procurator Fiscal **no** lines, drains and tubes should be removed.
11. All wards/departments have a copy of 'Getting it Right at the End – Caring for the Dying and bereaved. It can also be found on the intranet
http://intranet/ccc_nhsg/5781.959.html?pMenuID=460&pElementID=959
12. Body bags should be used if appropriate (See Infection Control Intranet advice)

REQUIREMENTS

1. Disposable plastic aprons
2. Disposable plastic gloves - unsterile
3. Trolley and/or basin
4. Basin with hot water – temperature 38-40⁰C
5. Disposable wipes and soap
6. Two towels
7. Brush and comb
8. Toothbrush and paste
9. Cotton wool, bandage, scissors, gauze swabs, adhesive tape e.g. zinc oxide tape 2.5cm white tape 1.25cm and waterproof dressing, e.g. Slek 2.5cm and 7.5cm wide
10. Disposable forceps
11. Disposable container for urine – if necessary
12. Disposable receiver/container
13. Sharps bin if appropriate
14. Incontinence pad
15. Polythene bags

16. Nightdress / pyjamas / shroud (unless specific clothing requested by patient or family)
17. Clean sheet
18. Two identibands / mortuary identification labels / valuables / property book
19. Indemnity form
20. Death notification book
21. Disposal bags as per NHSG waste policy (See intranet - Infection prevention and control)
22. Infection Control Notification Sheet (See intranet – Infection Prevention and control)
23. Bags for patient's personal possessions
24. Laundry skip and appropriate bags for soiled linen

Procedure		Rationale	
1.	Inform and offer support to relatives and /or next of kin. Offer support of the Hospital Chaplain or other religious leader. Provide bereavement pack with information booklets "Help for you following a bereavement". Inform porters of time of death.	1.	To ensure relevant individuals are aware of patient's death.
2.	Inform other patients and discuss issues as appropriate.	2.	Other patients are often aware that a patient has died and should be offered support and reassurance to allay misconceptions and fears.
3.	Document time of death in nursing kardex/notes	3.	To ensure that all relevant documentation has been completed.
4.	Put on gloves & apron.	4.	To reduce risk of contamination with body fluids and to reduce risk of cross infection.
5.	Close screens.	5.	To ensure adequate privacy.
6.	Lay the body flat, straighten limbs. Gently close the eyes. Clean and insert dentures if appropriate. Place a pillow under the chin to support the jaw if required.	6.	To maintain the patient's dignity for future management of the body as Rigor Mortis occurs between 2-4 hours after death.
7.	Prepare requirements.	7.	To ensure that all necessary requirements are available.
8.	a) Remove rings and jewellery in the presence of another nurse. List these on the indemnity form. b) If relatives request that jewellery or items of religion, culture or faith remain on the body then they should be taped and recorded in nursing notes and indemnity form.	8.	To meet with legal requirements, cultural practices and the wishes of the relatives.
9.	a) Apply pressure above the symphysis pubis, empty bladder using a receiver to collect the urine. b) If urinary catheter is in situ, drain urine, deflate the balloon and remove. c) If stoma present, pad and cover with waterproof dressing.	9.	a) To minimise the risk of excretion of fluids after death.

10	<p>a) Where present aspirate nasogastric tube and remove.</p> <p>b) Where present remove peripheral lines and cannulae and apply pressure before covering with waterproof dressing.</p> <p>c) Where present remove endotracheal tube, according to local protocol.</p> <p>d) Where present remove tracheostomy tube, pad and cover with waterproof dressing.</p> <p>e) Central Venous Lines: Long Line Feeding Tubes: Wound Drainage Tubes: Chest (Inter Costal) Drain: - All lines should be left in situ if death is reported to Procurator Fiscal or if the patient is going for post mortem. Cut half an inch above skin level ensuring the position of tube (s) is not altered. Plug any lines or tubes, e.g. use a spigot. Pad and cover with waterproof dressing.</p> <p>f) Septic foci or wounds should be padded and covered with a waterproof dressing.</p> <p>g) Suctioning of the oropharynx in previously intubated patients.</p>	10.	<p>a) To minimise the risk of excretion of fluids after death as well as the risk of infection.</p> <p>b) As above</p> <p>c) As above</p> <p>d) As above</p> <p>e) To allow position of tubes and lines to be checked by pathologist.</p> <p>f) To minimise the risk of excretion of fluids after death as well as the risk of infection to staff. Open wounds pose a health hazard to staff coming in contact with the body.</p> <p>g) Suctioning of the oropharynx can help to clear excess oral secretions</p>
11	<p>Wash and dry the body, clean nostrils, ears, mouth, clean nails, unless requested not to do so for religious/cultural reasons. Mouth and teeth should be cleaned with a toothbrush or with mouthcare foam sponges/gauze</p>	11.	<p>For hygienic and aesthetic reasons.</p>
12	<p>a) Place incontinence pad under the buttocks.</p> <p>b) Dress the body in a nightdress/pyjamas, or shroud (unless specific clothing requested by patient or family)</p>	12.	<p>a) To absorb any excretions</p> <p>b) To ease handling and prevent damage to the legs</p>

13	Tie the legs together at the knees and ankles using white 1.25cm ribbon gauze if required	13.	For religious or cultural reasons and to meet family's or carer's wishes.
14	Attach identiband containing date and time of death, name, chi number/ unit number, date of birth and ward number to wrist. (Leave original ID band in place).	14.	To ensure correct and easy identification of the body in the mortuary/undertaker.
15	Place sheet under the body.	15.	In preparation for wrapping the body.
16	Lay the patient's arms straight by their side.	16.	To prevent damage to the arms and hands.

The body must be checked by a qualified nurse before closing the sheet.

17	Cover the patient with a sheet as per diagram.	17.	To secure the sheet.
18	Secure the sheet with 2.5cm zinc oxide tape.	18.	Pins must not be used as they are a health and safety hazard to staff.
19	Fix the mortuary label and the Infection Control Notification to the sheet, over the chest with tape. If a body bag is required then the label and Infection Control notification should be placed in the appropriate pockets of the bag.	19.	To identify the body and make those coming into contact with the body aware of any risk. To minimise infection risk or to contain any body fluids which may be excreted after death.
20	According to hospital policy request portering staff to remove the body.	20.	Decomposition occurs rapidly, autolysis and growth of bacteria are delayed if the body is cooled.
21	Screen off area where removal of body will occur.	21.	To avoid causing unnecessary distress to other patients, relatives and staff.
22	Remove gloves and apron. Dispose of equipment according to local policy and wash hands	22.	To minimise risk of cross infection and contamination.
23	Record all details and actions within the nursing documentation.	23.	To record the time of death, names of those present and names of those informed.
24	Transfer property, patient records etc to the appropriate administrative department.	24.	To enable admin department to process the formalities following death.

Before releasing the body to the mortuary/undertaker, please go through the following checklist:

Checklist

- Identification
 - * Check label placed on chest (or body bag pocket)
 - * Check nameband on wrist or ankle.

- Valuables

Two staff members to check and list all items belonging to deceased on indemnity form and sign when doing so.

Check ward security/valuables box to ensure deceased does not have valuables there.

Put any jewellery in Jewellery box (code for ordering SMC 520), place in security/valuables box, or return to relatives.

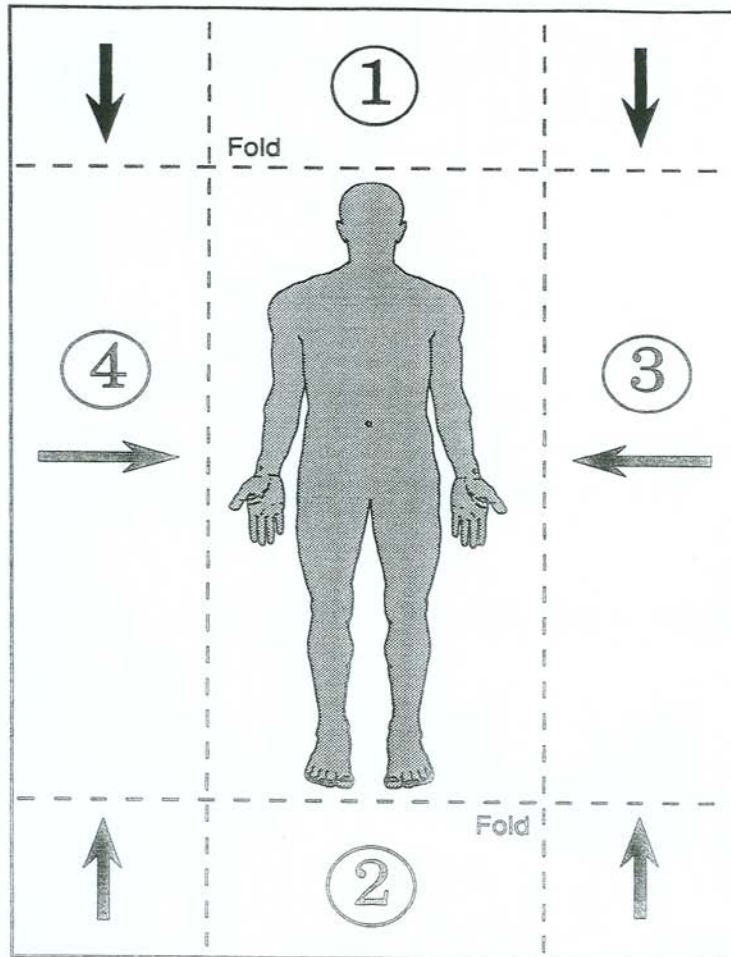
Ensure that the indemnity form has all sections completed.

Ensure two staff members witness collection of valuables by next of kin.

Ensure indemnity form is sent to general office or appropriate administration department when fully completed. If clothes/items are donated to ward this must also be documented on form.

LAST OFFICES

Sequence of sheet folds (1 - 4)



References

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PATTISON N (2008) – Care of patients who have died. *Nursing Standard* 22,28, 42-48

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Scottish Government 2008 (www.scotland.gov.uk)

Caring for Muslim Patients - Second Edition - 2008 – Edited by Aziz Sheikh and Abdul Rashid Gatrad

Appendix 7

Forms and paperwork commonly used when someone dies in hospital

Please write in the location of these forms in your ward or department and if necessary their destination.

Document	Location	Purpose	Completed by	Destination
Notice of Death			Nursing Staff	
Indemnity Form		Record of returning patient property.	Next of kin or representative and nursing staff returning patient property	
Mortuary Tag		A method of identification of the deceased although not definitive.	Nursing staff carrying out last offices	Attached to outside of the sheet, or in the body bag pocket in which the deceased is wrapped.
Infection Notification Sheet		Legally required that everyone coming into contact with the deceased is aware of any risk.	Nursing staff carrying out last offices or medical staff	Attached to outside of the sheet, or in the body bag pocket in which the deceased is wrapped.
(Medical Cause of) Death Certificate		Required for registration of death	Medical staff certifying death	Usually given to the next of kin or collected on the family's behalf from the ward

(Form F11)				by their representative
Cremation papers (Forms B & C)			Two members of medical staff, Part B by someone who has been involved in patient care and Part C by someone who is five years post registration but has not been involved in patient care.	Usually collected by funeral directors from the General Office or Mortuary. As a rule these must not be given to the family and never put in the internal mail.
Post Mortem Authorisation Pack		Legally required for a medical interest post mortem	Suitably qualified member of staff and next of kin.	Mortuary Foresterhill. Please contact staff on 52112
Post Mortem Requisition Form		Outline of reasons for post-mortem and specific questions being asked about the cause of death and other pathology	Medical staff requesting the post mortem.	Mortuary Foresterhill. Please contact staff on 52112
Implant Removal Form		Allows APT staff to remove implants from the deceased in order to allow cremation	Member of staff and next of kin.	Mortuary Foresterhill. Please contact staff on 52112

Medical Cause of Death Certificate (Form 11) - This is signed by a doctor and is required for registration of death. It will be retained by the registrar.

Certificate of Registration of Death (Form 14) - This is issued by the registrar of the district at the time of registration of death. It will be given to the family to take to the funeral directors so they can make funeral arrangements. It will be retained by the burial or cremation authority.

Extract of an Entry in the Register of Deaths - Commonly known as a 'copy of the death certificate', this is issued by the registrar of the district at the time of registration of death. There is a fee for this and is required for insurance, banking, pension or other purposes. This is the only official document which will be left with the family after the funeral has taken place.

Registration or Notification of Death Form (Form BD8) - This is issued by the registrar of the district at the time of registration of death. It is for use in adjusting Social Security Benefits.

Application for Cremation Certificate (Form A) - This is required for all cremations and is completed and signed by a responsible person representing the family (applicant) and the funeral director. It is given to and retained by the cremation authority.

Certificate of Medical Attendant (Form B) - This is required for cremation and is completed and signed by a doctor who has attended the deceased before death and who has seen and identified and examined the deceased after death. It is passed to the medical referee with Forms A & C. It is given to and retained by the cremation authority.

Confirmatory Medical Certificate (Form C) - This is required for cremation and is completed and signed by a doctor of not less than five years standing who has seen and examined the deceased after death. It is passed to the medical referee with Forms A & B. It is given to and retained by the cremation authority.

Procurator Fiscal Certificate for Cremation (Form E1) - This is required for cremation where there is procurator fiscal involvement in the death and supersedes Forms B & C. It is given to and retained by the cremation authority.

Certificate of Delivery of a baby (fetus) of less than 24 weeks gestation - This is completed and signed by a registered midwife or a medical practitioner. It is given to the family to take to their funeral director or for hospital arranged burial or cremation given to the mortuary staff. It will be retained by the cemetery or cremation authority.

Certificate of Stillbirth (Form 6) - This is signed by a doctor and is required for registration of a stillbirth. It will be retained by the registrar.

Certificate of Registration of Stillbirth (Form 8) - This is issued by the registrar of the district at the time of registration of stillbirth. It will be given to the family to take to the funeral directors so they can make funeral arrangements. It will be retained by the burial or cremation authority.

Stillborn Child Certificate for Cremation - This is required for cremation. It is completed by a registered medical practitioner who was present at birth and is needed instead of Forms B & C. It is given to and retained by the cremation authority.

Recommended reading

All in the End is Harvest: An Anthology for Those who Grieve, edited by Agnes Whitaker. London, Darton, Longman & Todd, published in association with Cruse Bereavement Care, 1984. ISBN 0-2325-1624-3.

An Intimate Loneliness : Supporting Bereaved Parents and Siblings, by Gordon Riches & Pam Dawson. Buckingham & Philadelphia PA., Open University Press, 2000. ISBN 0-335-19972-0. Discusses models of grief, adjustment for bereaved parents and family, and professional support in a postmodern world.

Arrangements for the Care of the Dying and Bereavement, Edinburgh, Scottish Office, 1997. A report by the National Panel for the Dying and Bereaved in Scotland. See also the Scottish Partnership Agency for Palliative and Cancer Care.

Badger's Parting Gifts, by Susan Varley. London, HarperCollins Children's Books, 2002. ISBN 978-0-0066-4317-5. Various editions, including first London, Andersen Press, 1984 and *Picture Lions*, 2002. Helping children come to terms with the death of those they love. Badger is old when he dies.

Bereavement in Late Life: Coping, Adaptation, and Developmental Influences, by Robert O Hansson. New York, American Psychological Association, 2007. ISBN 978-1-5924-7472-2.

Bereavement Narratives : Continuing Bonds in the Twenty-First Century, by Christine Valentine. London & New York, Routledge, 2008. ISBN 978-0-415-45730-9.

Beyond the Horizon : A Search for Meaning in Suffering, by Cicely Saunders. London, Darton Longman & Todd, 1990. ISBN 0-232-51875-0. Classic by founder of the St Christopher's Hospice. Discusses anger and guilt, suffering and dying, being left behind, getting going again, with readings from Christian and non-Christian writers.

Brief Interventions with Bereaved Children, edited by B Monroe & F Kraus. London & New York, Oxford University Press, 2005. Contact between healthcare professionals and bereaved children is often brief but also profound, within the context of therapeutic care.

Caring for Dying People of Different Faiths, by Julia Neuberger. Third edition. Abingdon (Oxford), Radcliffe Medical Press, 2004. ISBN 1-857-75945-1. Discusses faiths/belief-systems from Judaism and Buddhism to Humanism, and advocates practical caring and cultural sensitivity: intended for health-care professionals and hospice staff.

Care of the Dying: A Pathway to Excellence, edited by John Ellershaw & Susie Wilkinson & Dame Cicely Saunders. Oxford, Oxford University Press, 2003. ISBN 978-0-19-850933-2.

Caring for the Dying at Home: Companions on the Journey, by David Colin-Thorne, Jane Maher & Keri Thomas. Abingdon (Oxford), Radcliffe Medical Press, 2003. ISBN 978-1-85775-946-4.

Clinical Standards for Specialist Palliative Care. Published by NHS Quality Improvement Scotland (Clinical Standards Board for Scotland, merged into QIS in 2003), June 2002. First published September 2001. ISBN 1-84404-066-6 For pdf document go to website www.nhshealthquality.org.uk.

A Code of Practice for the Diagnosis of Brain Stem Death : Including Guidelines for the Identification and Management of Potential Organ and Tissue Donors. London, Department of Health, March 1998.

Communicating with Dying People and their Relatives, by Dorothy Whyte & Jean Lugton. Abingdon (Oxford), Radcliffe Medical Press, 2002. ISBN 978-1-8577-5584-8. *Concentrates on communication issues around terminal care and bereavement.*

Cot Death : The Facts, by Jane Chumbley. London, Ward Lock, 1997. ISBN 0-7063-7433-9. *Discusses likely causes like sleeping position and bed-sharing and mattresses, and the impact of cot death on the family.*

Counselling for Grief and Bereavement, by Geraldine M Humphrey & David G Zimpfer. London & Thousand Oaks CA & New Delhi, Sage Publications, 1996. ISBN 0-8039-8404-9. *Bereavement counselling approach covers family grief, groups, suicide, murder, AIDs, miscarriage, and grief resolution.*

Counselling in Terminal Care and Bereavement, by Colin Murray Parkes, Marilyn Relf & Ann Couldrick. Leicester, BPS Books, 1996. ISBN 1-8533-178-7.

The Courage to Grieve: Creative Living, Recovery and Growth through Grief, by Judy Tatelbaum. London, Vermilion, 1997. ISBN 0-7493-0936-9. First published London, Cedar Books (Heinemann), 1981. *Gestalt psychology approach by US author to loss, grief, loneliness, resentment, loss of the will to live, self-help and breaking through the denial of death.*

Dealing with Death : Practices and Procedures, by Jennifer Green & Michael Green. London, Jessica Kingsley Publishers, 2006. ISBN 978-1-8431-0381-3. Earlier edition, London, Chapman & Hall, 1992.

The Death of an Adult Child, by J W Blank. Amityville NY., Baywood, 1998. *Draws on letters to the newsletter of The Compassionate Friends and describes the experience of bereaved parents.*

Difficult Conversations in Medicine, edited by Elizabeth Macdonald. London & New York, Oxford University Press, 2004. ISBN 978-0-1985-2774-8. *Perceptive resource, not just for doctors.*

The Early Days of Grieving, by Derek Nuttall. London, Darton, Longman & Todd, 2006. Revised and updated edition from earlier edition published by Beaconsfield in 1991. ISBN 0-2325-2644-3.

Enduring, Sharing, Loving: For All Those Affected by the Death of a Child, by Marilyn Shaw. London & Liverpool, Darton, Longman & Todd in association with the Alder Centre (Royal Liverpool Children's NHS Trust, Alder Hey, Liverpool), 1992. ISBN 0-2325-2010-0. *For all those affected by the death of a child, above all from cancer. The Child Death helpline at the Alder Centre is 0800 282 986.*

Everybody's Death Should Matter to Somebody: Care of the Dying and the Bereaved in Scotland, by the Scottish Health Service Advisory Council. Edinburgh, Stationery Office Books, 1992. ISBN 978-0-1149-4193-2. Information about the Stationery Office, formerly HMSO, can be found at www.tso.co.uk. The main retail outlet in Scotland is TSO, 71 Lothian Road, Edinburgh EH3 9AZ. *The care of the dying and the bereaved in Scotland: a review and recommendations.*

Facing Grief: Bereavement and the Young Adult, by Susan Wallbank. London, Lutterworth Press, 1997. ISBN 0-7188-2807-0.

Final Gifts: Understanding and Helping the Dying, by Maggie Callanan & Patricia Kelley. London, Hodder & Stoughton, 1992. ISBN 0-3405-7481-X. *Understanding the experience of death and the messages the dying communicate when letting go. The authors draw on hospice experience.*

Final Reminder: How I Emptied My Parents' House, by Lydia Flem. London, Souvenir Press, 2005 (paperback 2006). ISBN 978-0-2856-3734-4. *Intense feelings when you have this taboo-breaking experience.*

The Forgotten Mourners : Guidelines for Working with Bereaved Children, by Susan C Smith. Second edition. London & Philadelphia PA., Jessica Kingsley Publishers, 1999. ISBN 1-8530-2758-8. *How children grieve and what adults and schools and social workers can do.*

The Goodbye Boat, by Mary Joslin (text) & Claire St Louis Little (illustrations). Oxford, Lion Publishing, 2005 (hardback 1998). ISBN 978-0-7459-4264-4. *A story book to help a child understand bereavement.*

Good Grief: Experiencing Loss, by Carol Lee. London, Fourth Estate, 1994. ISBN 1-8570-2184-3. *Grief as a period of learning, even comfort from others, revealing hidden perspectives like the possibility of new beginnings.*

Good Practice in Hospital Care for the Dying, by Alix Henley. Second edition. London, King's Fund, Project Paper 61, 1988. First edition published by *King Edward's Hospital Fund for London*, 1986. *Good practice in the care of dying patients and their relatives.*

Grief and Bereavement: Understanding Children, by Ann Couldrick. Oxford, Sobell Publications, Sir Michael Sobell House, 1988. ISBN 978-0-9517-371-2. *See also When Your Mum or Dad has Cancer.*

Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner, by *J William Worden*. Third edition. London & New York, Brunner-Routledge, 2003. Earlier published New York, Springer, 2001. ISBN 978-1-5839-1941-5. Introduction for health-care professionals and counsellors, including suicide and abortion and the personal grief of the counsellor.

Grief in Children :A Handbook for Adults, by *Atle Dyregrov*. London & Bristol PA., Jessica Kingsley Publishers, 1991. Norwegian expert discusses handling death at different ages and in a school setting.

A Grief Observed, by *C S Lewis*. London, Faber & Faber, 1966. ISBN 978-0-5710-6624-7. Numerous later editions. Author of *The Screwtape Letters* on the death of his wife.

A Guide to Faith Communities in Scotland. Glasgow, Scottish Inter-Faith Council, 2004. ISBN 1-857-75584-7.

Guiding a Child Through Grief, by *Mary Ann Emswiler*. New York, Bantam, 2000. ISBN 0-5533-8025-7.

Helping Children Cope with Grief: Facing a Death in the Family, by *Rosemary Wells*. London, Sheldon Press (SPCK), 1988. ISBN 0-8596-9559-X. Discusses childhood grief, terminal illness and unexpected death, the surviving parent, attitudes in school and religion.

How Many Times Can You Say Goodbye? Living with Bereavement, by *Jennifer Pardoe*. London, Triangle (SPCK), 1991. ISBN 0-2810-4484-8. Feeling loss, society and grief, facing anticipated and sudden death, suicide and the response of the church, practical and emotional help, spiritual issues and the search for meaning.

How to Break Bad News : A Guide for Health-care Professionals, by *Robert Buckman*. Basingstoke, Pan Books, 1994. ISBN 978-0-333-54864-6. First published by Macmillan, 1992. Doctor/nurse-patient communication, attitudes to death, counselling and interviewing.

Interventions with Bereaved Children, edited by *Susan C Smith & Sister Margaret Pennells*. London & Bristol PA., Jessica Kingsley Publishers, 1995. ISBN 1-8530-2285-3. Work with individuals, families, groups and specific client groups like disabled people, with some US projects (including art therapy).

Introducing Palliative Care, by *Robert Twycross*. Fourth edition. Abingdon (Oxford), Radcliffe Medical Press, 2002. ISBN 1 -8577-5915-X. Good basic text useful for all members of the multidisciplinary team.

Just My Reflection... Helping Parents to Do Things their Way When their Child Dies, by *Sister Frances Dominica*. London, Darton Longman & Todd, 1997. ISBN 978-0-232-52211-2. The death of a child, telling relatives and friends, the funeral and afterwards, Christian and non-Christian faiths, with spiritual and other readings and a service sheet. Spiral binding.

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Letting Go : Caring for the Dying and the Bereaved, by *Ian Ainsworth-Smith & Peter Speck.* London, SPCK, 1982. ISBN 0-2810-3861-9.

Literature Review on Bereavement and Bereavement Care. *Aberdeen, The Joanna Briggs Institute, The Robert Gordon University, January 2006.* Bibliographic scoping review. Contact Dr Peter Wimpenny at RGU.

Living with Bereavement, by *Sue Mayfield.* Oxford, Lion Publishing, 2008. ISBN 978-0-7459-5295-6. When someone dies, funerals, anger and guilt, loneliness and yearning, faith and hope.

The Lone Twin: A Study in Bereavement and Loss, by *Joan Woodward.* London, Free Association Books, 1998. ISBN 978-1-8534-3374-0. Twin loss discussed by a psychotherapist.

Loss and Bereavement in Childbearing, by *Rosemary Mander.* London & New York, Routledge, 2006. ISBN 978-0-415-35411-0.

Loss, Change and Bereavement in Palliative Care, by *Pam Firth.* Buckingham & Philadelphia PA., Open University Press, 2005. ISBN 0-3352-1323-5. How do professionals meet the needs of bereaved people?

Love and Loss : The Roots of Grief and Its Complications, by *Colin Murray Parkes.* London & New York, Routledge, 2006. ISBN 978-0-415-39041-5. Loving and grieving are two sides of the same coin : we cannot have one without risking the other.

Michael Rosen's Sad Book, by *Michael Rosen & Quentin Blake.* London, Walker Books, 2004. ISBN 978-0-7445-9898-8. Reprinted as a paperback in 2008, ISBN 978-1-4063-1316-1. Honest book for children and adults about coping with sadness, with original illustrations.

Mikki has Cancer, by *Eileen Wheeler & Iiris Maanoja.* Aberdeen, Cancer Link Aberdeen & North, 2005. ISBN 978-0-9551-6420-0. The impact the diagnosis of childhood cancer can have on a sibling's life.

Miscarriage, Stillbirth and Neonatal Death : Guidelines for Professionals, by *Nancy Kohner & Alix Henley.* London, SANDS (Stillbirth and Neonatal Death Society), 1991. ISBN 978-1-8699-0315-2. Practical advice for people and families who experience these events. See also **When a Baby Dies.**

New Journeys Now Begin : Learning on the Path of Grief and Loss, by *Tom Gordon.* Glasgow, Wild Goose Publications, 2006. ISBN 978-1-9050-1008-0.

Nursing the Dying Patient: Caring in Different Contexts, by John Costello. Basingstoke, Palgrave Macmillan, 2004. ISBN 978-0-333-9803-5.

On Bereavement: The Culture of Grief, by Tony Walter. Philadelphia PA. & Milton Keynes, Open University Press, 1999. ISBN 0-2352-0080-X.

On the Death of a Child, by Celia Hindmarch. Abingdon (Oxford), Radcliffe Medical Press, 2000. ISBN 1-8577-5445-X.

Palliative Care, by Christina Faull & Richard Woof. London & New York, Oxford University Press, 2002. ISBN 978-0-192-63280-9. Easy-to-read introduction to the palliative care approach.

Patients Who Die in Hospital. National Health Service circular GEN (1992) 33 updated by GEN (1994) 4. Guidance on how to help dying hospital patients and their families and a resource document on standards of quality in care.

The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provision in the NHS (UK) : A Scoping Review of Recent Research, by Ham'et Mowat. Aberdeen, Mowat Research Limited, 2008. Historiographic and bibliographic report.

Recovery from Bereavement, by Colin Murray Parkes & Robert S Weiss. New York, Basic Books, 1983. ISBN 978-0-4650-6868-5.

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Religions and Cultures in Grampian, A practical guide for health and social care staff to the diversity of beliefs, customs and cultures of the people of Grampian. NHS Grampian Spiritual Care committee 2nd edition 2009.

Responding to Grief: Dying, Bereavement and Social Care, by Caroline Curren. Basingstoke & New York, Palgrave Macmillan, 2000. ISBN 978-0-333-73639-5.

A Special Scar: The Experience of People Bereaved by Suicide, by Alison Wertheimer. London & New York, Brunner-Routledge, 2001. ISBN 0-4152-2062-2. Earlier edition Tavistock/Routledge, 1991. Discusses the stigma of suicide and bereavement arising from suicide, and offers counselling advice to families who have experience of it.

Sudden Death, by Bob Wright. Second edition. London, Churchill Livingstone, 1991. ISBN 978-0-443-04133-4. Intervention skills for the caring professions.

Sudden Death in Childhood: Support for the Bereaved Family, by Ann Dent. Oxford, Butterworth-Heinemann, 2004. ISBN 0-7506-5646-8. To lose a child is not 'appropriate' and the feelings involved become even more difficult to deal with: implications for practitioners.

Supporting Bereaved Young People, by Lynne Edwards, Janet Powney & Ann Dockrell. Edinburgh, Scottish Council for Research in Education, 2000. A copy can be downloaded at www.scre.ac.uk/bereavement/.

Talking about Bereavement, by Geraldine Abrahams. Edinburgh & Glasgow, Health Scotland, March 2006. Available as pdf file, ISBN 1-84485-348-9, on the Health Scotland website at www.healthscotland.com/resources/publications. Large print, Braille and audio versions are available. *'For people who have recently been bereaved, for their families and friends, and for people who want to know more about the subject'*. Recommends further reading and online sources.

Talking with Children and Young People about Death and Dying: A Workbook, by Mary Turner. London & Philadelphia PA., Jessica Kingsley Publishers, 1998. ISBN 1-8530-2563-1.

Through Grief: The Bereavement Journey, by Elizabeth Collick. Foreword by Claire Rayner. London, Darton, Longman & Todd, 1986. ISBN 0-2325-1682-0.

UK Hospital Policy for Organ Donation and Tissue Donation. Bristol, UK Transplant, Spring 2003. UK Transplant is part of NHS Blood and Transplant and, from 2008, is called the Organ Donation and Transplantation Directorate of NHS Blood and Transplant. Its website at www.uktransplant.org.uk explains its role and contains numerous policies and statements. Tel. 0117-975-7575 and enquiries@uktransplant.nhs.uk.

The Vale of Tears: Experiencing Growth through Loss (A Pilgrim's Guide to the Grief Journey), by Robert Weston. Chichester, New Wine Press, 2008. ISBN 978-1-905991-20-4. *The courage to keep going in faith.*

Waterbugs and Dragonflies : Explaining Death to Children, by Doris Stickney. Revised edition. London, Continuum, 1997. ISBN 0-8264-6458-0. First published by The Pilgrim Press, 1982 and Mowbray, 1984. *Explains death to young children from a Christian viewpoint and sees parental role as a witness to faith.*

What to Do after a Death in Scotland: Practical Advice for Times of Bereavement. Eighth edition. Edinburgh, Scottish Government Publications, accessed on website www.scotland.gov.uk/Publications/20Q8/ in 2008. *Practical advice for times of bereavement - medical certificate, donation of body parts, registering a death, the funeral and afterwards.*

What Do We Think about Death?, by Karen Bryant-Mole. Hove, Hodder-Wayland, 1998. ISBN 978-0-7502-3218-0. *For young people.*

When a Baby Dies : The Experience of Late Miscarriage, Stillbirth and Neonatal Death, by Alix Henley & Nancy Kohner. London & New York, Routledge, 2001. ISBN 978-0-415-25275-1. Original edition London, Unwin Health, 1991. *Stories of parents whose babies died either before birth or afterwards.*

When Parents Die: Learning to Live with the Loss of a Parent, by Rebecca Abrams. Second edition. London & New York, Routledge, 1999. ISBN 0-4152-0065-2. *Compassionate personal account of losing a parent when you are a teenager.*

When Someone Dies : A Practical Guide to Holistic Care at the End of Life, by Hannah Cooke. Oxford, Butterworth-Heinemann, 2000. ISBN 978-0-7506-4084-7.

When Your Mum or Dad has Cancer, by Ann Couldrick. Oxford, Sobell Publications, Sir Michael Sobell House, 1997 (printed for The Child Bereavement Trust, Beaconsfield, Bucks, tel.01494-678088). Original edition 1991. ISBN 978-0-9517-5373-6. *Pamphlet of text and illustrations for young children.*

Where Did Grandad Go?, by Catherine House & Honor Ayres. Oxford, The Bible Reading Fellowship, 2006. ISBN 978-1-84101-502-6.

Without You: Children and Young People Growing Up with Loss and Its Effects, by Tamar Granot. London, Jessica Kingsley Publishers, 2005. ISBN 978-1-8431-0297-7. *Practical and sensitive advice on how best to support children; includes suicide, the death of a sibling, and parental abandonment.*

Words to Comfort, Words to Heal: Poems and Meditations for Those Who Grieve, edited by Juliet Mabey. Oxford, Oneworld Publications, 1998. ISBN 978-1-8516-8154-9. *Anthology of poems and a variety of religious writings.*

Working with Young People Experiencing Bereavement, by Katherine Miller. Norwich, University of East Anglia School of Social Work, 2005. ISBN 1-8578-4109-3.

You'll Get Over It: The Rage of Bereavement, by Virginia Ironside. London, Penguin Books, 1997. ISBN 978-0-1402-3608-8.

You're Not Alone, compiled by Yvonne Johnson & Wendy Freeman for the Isabel Hospice (Griffin House, Watchmead, Welwyn Garden City, Herts AL7 1LT). Published Knebworth Herts., Able Publishing, 2000. ISBN 978-01-9036-0706-0.

Sources on the NHS Grampian intranet

Fair for All: Working towards Culturally Competent Services, Scottish Executive, Health Department, 2002.

Local Palliative Care Guidelines

NHSG Advance Directive (Living Wills) Policy

NHSG Not for Resuscitation Policy

NHSG Spiritual Care Policy

Relevant journal sources

Ageing and Society, Arts in Psychotherapy, Bereavement Care, British Medical Journal, Cancer Nursing, Death Studies, European Journal of Cancer, Gerontologist, Hospice Journal, International Journal of Palliative Nursing, Journal of Counseling Psychology, Journal of Death and Dying, Mortality, Omega Journal of Death and Dying, and Palliative Medicine.

Nursing Times (weekly professional journal) provides regular coverage of bereavement-related nursing and medical issues (such as caring for bereaved people, pastoral and spiritual support in bereavement care, dying with dignity, depression in older people, and carrying out the last offices). The Scottish Journal of Health Chaplaincy (paper and online versions) offers a regular column called 'The Orere Source' abstracting the pastoral care and health-care literature.

Useful addresses

Cancer Link Aberdeen & North, *CLAN House, Caroline Place, Aberdeen AB25 2TH, tel. 01224 64700, www.clanhouse.org.uk_ Email clan-aberdeen@btconnect. com.*

The Compassionate Friends, *53 North Street, Bristol BS3 1EN, tel. 0845 123 2304, www.tcf.org.uk_ Advice and information for bereaved parents and their families.*

Counselling and Psychotherapy in Scotland (COSCA), *18 Viewfield Street, Stirling FK8 1UA, tel. 01786 475140, www.cosca.org.uk.*

Cruse Bereavement Care Scotland, *Riverview House, Friarton Road, Perth PH2 8DF, tel. 01738 444 178, www.crusescotland.org.uk_ Branches throughout Scotland. Numerous leaflets and short publications are available, including *After the Death of Someone Close by Caroline Morton, Early Days in Widowhood by Margaret Torrie, and My Father Died/My Mother Died by Susan Wallbank (for teenagers who have lost a parent).* Cruse publish the quarterly Bereavement Care Journal.*

The National Association of Bereavement Services, *20 Norton Folgate, London E1 6DB, helpline 020 7247 1080.*

Stillbirth and Neonatal Death Society (SANDS), *28 Portland Place, London W1B 1LY, helpline 020 7436 5881. www.uk-sands.org.*

Useful websites

www.cancerbackup.org.uk

Helping people live with cancer. Run by Macmillan Cancer Support. Information advice and support for cancer patients, their families and carers (such as kidney, ovarian, prostate cancer, material for children and audio material). Helpline 0808 800 1234.

www.childbereavement.org.uk
The Child Bereavement Charity (earlier Trust). Support and information helpline
01494446648.

www.clanhouse.org.uk
Cancer Link Aberdeen & North, CLAN House, Caroline Place, Aberdeen AB25
2TH, tel. 0122464700.

www.leukemicare.org.uk
Leukemia Care Society. Tel, 0190 533 000 and 24-hour helpline 0800 169
6680.

www.macmillan.org.uk
Macmillan CancerCare. tel. 0808 808 2020.

www.miscarriageassociation.org.uk
The Miscarriage Association, c/o Clayton Hospital, Northgate, Wakefield WF1
3JS, helpline 01924-200795,

www.miscarriagesupport.org.uk
Scottish Care and Help on Miscarriage (41 Merryland Street, Glasgow G51 2QG,
tel.0141-445-3727). Fact-sheets on miscarriage, blighted ovum pregnancy, diet, and
much else.

www.patient.co.uk
Health information for patients. Bereavement-related information includes
'Bereavement - a Self-Help Guide'. Very comprehensive online source.

www.sidscotland.org.uk
The Scottish Cot Death Trust. (Royal Hospital for Sick Children, Yorkhill,
Glasgow G3 8SJ, tel.0141 357 3946).

www.stchristophers.org.uk
St Christopher's Hospice, 51-9 Lawrie Park Road, London SE26 6DZ. Tel. 020
8768 4500 (general inquiries) and 4660 (library). Recommended readings on
bereavement, including children's books, available from their bookshop.

www.tht.org.uk
Terence Higgins Trust (for gay and lesbian bereavement care). Three centres in
Scotland : Glasgow (134 Douglas Street, Glasgow G2 4HF, tel. 0141 332
3838), Aberdeen (11 Waverley Place, Aberdeen AB10 1XH, tel. 0845 241
2151), and Inverness (34 Waterloo Place, Inverness IV1 1MB, tel. -1463 711
585).

(Getting It Right At the End Recommended Reading 2008
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Insert picture: At the Horses Shed

Index

Aberdeen Maternity Hospital	Counselling	18
48, 62, 75	Cremation papers	63
Accident & Emergency Department	Cruse (Bereavement Care)	69
41, 43, 68	Cultural differences	12, 26
Accommodation list	Deaf	See British Sign Language
Advance Directives (Living Wills)	Death certificate	55
Allowing a patient to die	Death Certificate	31, 58, 60, 61
Anatomical pathology technician	Death, moment of	24, 26
Anatomy department	Disabilities	12
64, 78	District Nurses	32
Answering questions	Do not resuscitate	14
Baby death	Dying at home	15, 55
Baby funerals	Elgin mortuary	39
Bequeathed organs	Ethnic minorities	12, 26
Bereaved Families Support Group	Everybody's death should matter to	
Bodies bequeathed to School of	somebody	7
Medical Sciences (Anatomy)	Facilities for visitors	22
64, 78	Fair for All	12
Brain stem death	Faith groups	
Breaking bad news	13, 16, 17, 26, 27, 33, 34, 35, 42	
10, 11, 12, 29, 41	Family conflicts	11, 21
British Sign Language (BSL)	Foreword	2
12, 76, 77	Funeral directors	30, 34, 55
Calling a Priest	General practitioners	
Calling relatives	15, 31, 32, 55, 58, 60	
Care managers	Giving time	10
See Social workers	Going home to die	15
Carers	Help for you following a bereavement	
20, 21	(NHS Grampian leaflet)	31, 60
Caring for dying patients	Holistic care	16
10	Hospital chaplains	
Caring for relatives	16, 34, 49, 55, 57, 69, 74	
21, 26, 29, 37, 46	How much to tell	11
Catholic	Individual care	13
See Roman Catholic	Information for relatives	60
Chaplains	Integrated health and social care	
See Hospital Chaplains	team	15, 31
Child death	Interpretation	76
50	Interpreter	12, 22, 31, 69, 76
Children	Jewish	62
30	Language barrier	12, 22
Children of dying patients	Language Line	12, 22, 31, 76
20, 23	Last offices	29, 31, 37, 47, 51, 53, 97
Christian churches	Leaving the hospital	28, 36, 53
17	Linus quilts	23, 54
Church of England	Living wills	14
See Scottish	Macmillan nurses	
Episcopal Church	14, 15, 18, 32, 57, 69	
Church of Scotland	Malcolm Sargent social worker	69
17, 33		
Churches		
17		
Clan Haven		
22		
Combined Child Health		
50		
Communicating with dying patients		
10		
Communication		
15		
Communication difficulties		
12, 22, 31		
Community hospitals		
11, 60		
Conflicts		
11, 21		
Consent for organ and tissue		
donation		
46		
Consent for post mortem examination		
61		
Contacting relatives		
15, 24, 28		
Continuing support		
36, 47		

Marie Cuire Cancer Care	15	Relatives' room	41
Media	32	Releasing information	31
Medical records	58	Religions	See Faith groups
Medical Sciences (Anatomy)	See Anatomy	Religions and Cultures in Grampian	13, 17, 27, 33, 35, 37, 42, 55
Memorial Book (AMH)	48	Religious care	16, 33
Minister	16	Religious minorities	12, 62
Mortuary	34, 38, 52, 53, 78	Removing bodies	37
Mortuary viewing area	28, 78	Respite care	15
Muslim	62	Responses to death	26
Mutilated bodies	39	Resuscitation	9, 14
Named nurse	21, 42	Returning property	43, 67
Neonatal death	48	Roman Catholic Church	17, 33, 35, 70, 75
Newspapers	See Media	Roxburghe House	13
No one should die alone	26	Royal Aberdeen Children's Hospital	50, 62
Not for Resuscitation policy (NHS Grampian)	14	SANDS (Stillbirth and Neonatal Death Society)	70
Notifying GPs	58, 60	Scottish Episcopal Church	17, 35, 70, 74
Occupational Health	57, 69	Sitting with dying patients	26
Operating theatre	44, 52	Social workers	18, 33, 48, 57, 72
Organ and tissue donation	22, 44, 52, 54	Specialist palliative care team	13
Organ and tissue donation - follow up care	46	Spiritual care	16, 33
Other patients	28, 36	Spiritual Care Policy (NHS Grampian)	12, 16
Pain	13	Staff support	57
Palliative care	13	Stillbirth	48
Palliative care guidelines	14	Sudden death	28, 40, 50
Patient property	43, 58, 67	Support for the newly bereaved	28, 32
Police	30, 42, 43, 69, 77, 82	Symptom control	13
Post mortem examination	43, 61, 78	Telephone enquiries	31, 52, 55
Practical questions	11	Telephone numbers	69
Priest, Roman Catholic	16, 17, 35	Theatre	44
Primary healthcare team	11, 14, 15, 31	Transfer of child's body home	54
Principles for care of the dying and bereaved	7	Transplant coordinator	45
Privacy	9, 10, 30	Unexpected death	See Sudden death
Procurator Fiscal	33, 38, 39, 43, 51, 54, 58, 60, 62, 63, 65, 70, 79, 84, 85, 90	Unresolved family conflicts	21
Queen Street Mortuary	38, 52, 54	Unrestricted visiting	20, 22
Red Cross House	22	Unwanted property	68
Referring doctor	15	Valuables	43, 67
Registrar	30, 55, 70	Viewing the body	28, 37, 42, 51, 78
Relatives	10, 15, 20, 21, 22, 23, 26, 28, 29, 30, 31, 32, 33, 34, 36, 37, 41, 43, 44, 45, 46, 60, 70	What to do after a death in Scotland (Booklet)	31, 60
		Where to care for dying patients	14
		Woodend Hospital mortuary	39