Clinical Practice Guidelines: Other/Verification of death & management of a deceased person

Policy code	CPG_OT_VDMD_0924
Date	18 September, 2024
Purpose	To ensure a consistent approach to verification of death and management of a deceased person.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
Source of funding	Internal – 100%
Author	Clinical Quality & Patient Safety Unit, QAS
Review date	18 September, 2027
Information security	UNCLASSIFIED – Queensland Government Information Security Classification Framework.
URL	https://ambulance.qld.gov.au/clinical.html

While the QAS has attempted to contact all copyright owners, this has not always been possible. The QAS would welcome notification from any copyright holder who has been omitted or incorrectly acknowledged.

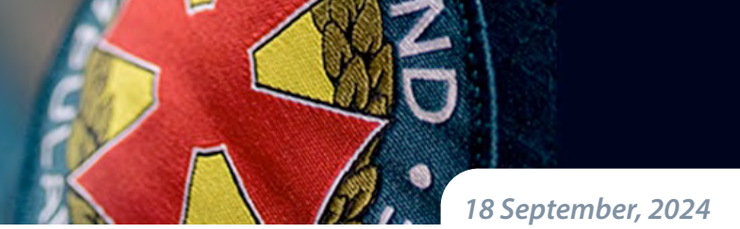
All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

Disclaimer

The Digital Clinical Practice Manual is expressly intended for use by appropriately qualified QAS clinicians when performing duties and delivering ambulance services for, and on behalf of, the QAS.

The QAS disclaims, to the maximum extent permitted by law, all responsibility and all liability (including without limitation, liability in negligence) for all expenses, losses, damages and costs incurred for any reason associated with the use of this manual, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.

Verification of death & management of a deceased person



18 September, 2024

It is not uncommon for ambulance clinicians to encounter death. Clinicians may be required to attend a patient who has died prior to their arrival at the scene or may be treating a patient who dies while receiving that treatment.[1] It is therefore essential that ambulance clinicians are familiar with the clinical, legal, and ethical obligations relevant to the death of a patient for whom ambulance services have been requested and provided.

In this Clinical Practice Guideline (CPG), the following topics are addressed:

- Verification of death
- Documentation of death: recording of life extinct (ROLE) on the *QAS Life Extinct Form*
- *Cause of Death Certificate* issued by a medical practitioner
- Reportable deaths – deaths that must be reported to the Office of the State Coroner
  - Violent or unnatural death
  - Death in suspicious circumstances
  - Health care related death
  - *Cause of Death Certificate* not likely to be issued
  - Death in care
  - Death in custody
- Notifying the Coroner or Police of a reportable death
- Interference with the body of a deceased person
- Preservation of evidence at the scene of a reportable death
- Relocation of a deceased person
  - Reportable death
  - Non-reportable death – by family engaged funeral director
  - Non-reportable death – by Government contracted funeral director
- Death during ambulance transport
  - Road transport
  - Air transport
- Death outside of Queensland
- Support for family of the deceased

Verification of Death

The ambulance clinician at the scene (see below*), must conduct a **clinical assessment to verify** that **death** has occurred. In circumstances where the patient is *exhibiting obvious signs of death* or has suffered injuries that are totally incompatible with life, there is no requirement to conduct an additional clinical assessment to verify the death. *Obvious signs of death* include:[2]

- ***Well established decomposition*** which has caused extensive discolouration of the skin, bloating of the body, putrefaction, and in some cases, larval infestation, and partial exposure of bones.
- ***Hypostasis*** which is the accumulation of fluid or blood in the lower parts of the body or those areas under the influence of gravity.
- ***Rigor mortis*** or stiffening of the muscles and joints of the body resulting in rigidity.
- ***Extensive trauma*** that has caused decapitation or cranial and cerebral destruction, severance of the torso or fragmentation of the body.
- ***Incineration*** causing charring and blackening of most of the body surface, with exposure of underlying tissues in some areas.

In the absence of *obvious signs of death*, the ambulance clinician must complete a clinical assessment and confirm the presence of the following assessment findings:

- No palpable carotid pulse; **and**
- No heart sounds heard for a continuous period of 30 seconds (using a stethoscope); **and**
- No breath sounds heard for a continuous period of 30 seconds (using a stethoscope); **and**
- Both pupils are fixed (not reacting to light) and dilated; **and**
- No patient response to centralised stimuli.

Each of the above listed criteria must be confirmed before verification of death can be made.[2]

*For the purposes of this CPG, only ambulance clinicians that are **registered paramedics**[3] or **medical practitioners** can verify death.

Documentation of Death

Following the verification of death, the clinician MUST complete a *Queensland Ambulance Service Life Extinct Form* (see attached).

The *QAS Life Extinct Form* is required to be completed in ALL CASES involving a death that has been verified by the ambulance clinician that attended the scene and verified that the patient was deceased.

The original *QAS Life Extinct Form*, once completed, must be provided to the Queensland Police Service (QPS) officers if police attend the scene, or left with the patient/patient's family so that the form can be available and provided to mortuary personnel or funeral directors.

The *QAS Life Extinct Form* is essential as it allows mortuary personnel, funeral directors, and QPS officers to arrange for the removal and transport of a person who is deceased.

The ambulance clinician must also complete an eARF and upload an image of the completed *QAS Life Extinct Form* into the eARF file.

Cause of Death Certificate

A *Cause of Death Certificate* is ***only to be issued in circumstances where the death is not a reportable death*** under the *Coroners Act*,[4] or where a Coroner authorises the patient's medical practitioner to issue a *Cause of Death Certificate*.[5]

If the death is not a *reportable death*, a *Cause of Death Certificate* **must be completed within 48 hours** of the patient's death.[6] A *Cause of Death Certificate* is a medical certificate in which a medical practitioner is able to record an opinion as to the probable cause of death, taking into account their knowledge of the patient's medical history, and the circumstances of their death.[6]

There is no requirement that the deceased consulted the medical practitioner within a specified timeframe prior to their death, and there is no requirement to examine the body of the deceased prior to completing the *Cause of Death Certificate*.[7]

If the patient's regular medical practitioner is not available to complete the *Cause of Death Certificate*, another medical practitioner can issue the certificate, provided they have had an opportunity to consider the patient's medical history by reviewing the patient's medical records or speaking to a medical practitioner who may have been involved with the patient's medical care,[7] and/or the paramedics that attended the patient at, or prior to the time the patient died.

If the ambulance clinician is unable to contact the patient's medical practitioner, the funeral director can do so after the body of the deceased has been collected. If a *Cause of Death Certificate* is not forthcoming within 48 hours, the funeral director will notify the QPS.

Reportable Deaths

A reportable death is defined in section 8 of the *Coroners Act 2003*. A person's death is reportable to the Coroner if:[8]

(a) the identity of the person is not known; or
(b) the death was a violent or unnatural death; or
(c) the death happened in suspicious circumstances; or
(d) the death was a health care related death; or
(e) a *Cause of Death Certificate* is unlikely to be issued (within 48 hours); or
(f) the death was a death in care; or
(g) the death was a death in custody; or
(h) the death happened during, or as a result of police operations.

The identity of the person is not known

Deaths involving a person of unknown identity can fall within three categories:[7]

- The deceased is found in a public place or place other than their place of residence or work and, at the time, do not have any legal identification on their person. Examples may include a vagrant, a jogger, a person found in the river or unmarked grave.

- The deceased is found in their usual place of residence and their identity is assumed however, there is no legal identification on the person, and no one is present to confirm the identity of the person.
- The person is involved in a multiple fatality incident and the identification of the persons involved will required an exhaustive inquiry.

Violent or unnatural deaths

Violent deaths fall within the category of unnatural deaths and for the most part, are readily identifiable. Unnatural deaths mostly involve circumstances such as accident, suicide, or homicide, the specific causes of which can be divided into three broad categories:[7]

- Acute effects of intoxication (alcohol, prescribed and illicit drugs, toxic substances).
- Deprivation of oxygen, food, or water (asphyxia, drowning, dehydration, starvation).
- Physical factors and exposure (trauma, fire, cold, electricity, radiation).

Deaths where neglect, including inadequate or delayed efforts by the person's carer to seek health care or treatment for the deceased person, in circumstances where that delay may have contributed to the person's death, may also be regarded as unnatural under the deprivation category, and should be reported.[7]

Suspicious circumstances

Suspicious circumstances largely involve deaths that are unnatural, such as a drowning, overdose, or traumatic injuries and where there is the possibility that another person was involved, and the death may be a homicide.[7]

Health care related death

A health care related death is one in which the health care that was provided caused, or contributed to the person's death, or was likely to have caused or contributed to the person's death.[9]

A health care related death also includes a death where a person dies at any time after health care was sought for the person, and where there was a failure to provide the health care, and the failure caused, or was likely to have caused, or contributed to the person's death.[10]

Health care for the purposes of the *Coroners Act* includes ***any health procedure or any care, treatment, advice, service, or goods provided for the benefit of human health***.[11]

A ***health procedure*** is defined as a ***dental, medical, surgical, or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative, or other drug***.[12]

> The death of a person who has self-administered, or been administered, a voluntary assisting dying substance under the *Voluntary Assisted Dying Act 2021* is **not** a reportable death.

Cause of death certificate not likely to be issued

The *Cause of Death Certificate* is to be **issued within 48 hours of the death**.

In order to complete a *Cause of Death Certificate*, a medical practitioner is required to form an opinion that the person has died from natural causes, and thereafter, record the **probable** cause of death.

If a cause of death certificate is not forthcoming within 48 hours, the funeral director will notify the QPS and the Office of the Coroner.[7]

Death in care

The death of specific vulnerable persons in the community are reportable, irrespective of the cause of death.[7]

Deaths in care have been classified into the following four categories:[7]

- A person who had a *disability* and who resided in supported accommodation and/or was receiving high-level support as a participant under the National Disability Insurance Scheme (NDIS) pursuant to the *Disability Services Act 2006*.[13]
- A person who was subject to treatment under the *Forensic Disability Act 2011*.[14]
- A person who was subject to involuntary assessment or treatment under the *Mental Health Act 2016*.[15]
- A child in the care or under the guardianship of the State under the *Child Protection Act 1999*.[16]

A disability is a condition that is attributable to an intellectual, psychiatric, cognitive, neurological, sensory, or physical impairment, which results in a substantial reduction of the person's capacity for communication, social interaction, learning, mobility, or self-care, resulting in the person needing support.[7]

A disability may be permanent, or of a chronic episodic nature.

Death in custody

The death of a person who, at the time of their death, was in police custody, or trying to escape from custody, or trying to avoid being put into custody.[17] An example of a person tying to avoid being put into custody is one who dies from injuries sustained in a road traffic crash while being pursued by police.

Notifying the Coroner or Police of a Reportable Death

In circumstances involving a **reportable death**, there is a mandatory requirement to report the death to the coroner in a timely manner.[18] To facilitate this, **ambulance clinicians must report the death directly to police** who will in turn, report the death to the coroner in the prescribed form.[19]

If the ambulance clinician is uncertain as to whether a death is reportable, the clinician may first seek direction from the *QAS Clinical Consultation & Advice Line,* and thereafter, if the clinician remains uncertain, report the death to police.

> If the death does not meet the criteria for a reportable death, there is no requirement to notify police. QPS are not required to attend a scene at which a non-reportable death has occurred.

Interference with the body of a deceased person

Once it has been determined that life is extinct, all resuscitation must be immediately withdrawn. Clinicians MUST NOT perform any invasive procedure or implement any form of treatment for any purpose whatsoever.

Preservation of Evidence at the Scene of a Reportable Death

A coroner is required to investigate a death that is a reportable death.[20] Depending on the circumstances relating to the death, the coroner is assisted by QPS officers and other specialist agencies relevant to the specific investigation.[7] Following completion of the investigation, the coroner **may** hold an inquest into the death if the coroner is satisfied it is in the public interest to do so.[21] An inquest however **must** be held in cases involving a reportable death that is a death in custody or a death in care.[22]

Essential to the investigative process, is the physical evidence that can be obtained from the scene, and the clinical records and other documentary evidence which provide details of the assessment and clinical management of the deceased at, or immediately prior to their death.

In circumstances involving a suspicious death, such as a suicide or homicide, or a violent death involving a road traffic crash or industrial accident, the scene should be preserved so that QPS officers can record accurate details relating to the scene as it was at the time of the patient's death.

If QAS clinicians provide care prior to verifying the patient is deceased, clinicians should be mindful of the requirement to ***preserve the scene*** and ***preserve the evidence at the scene***, to the extent that it is practical to do so.

To assist QPS officers and other investigators, ambulance clinicians should observe the following:[23,24]

- Be conscious of the ambulance vehicle and avoid driving over tyre tracks
- Restrict access to the scene and the patient until police arrive
- Minimise disturbance to the scene – use one entrance/exit and walk in a set path
- Avoid stepping in pools of blood
- Wear gloves
- Avoid touching or relocating any item at the scene unless it is necessary to do so
- If items are moved, document who moved it, when and why it was moved, and the location from where it was moved and where it was placed
- Preserve the patient's clothing
- If clothing is required to be cut, avoid cutting through blood stains and knife/bullet holes in the clothing
- Bag and label clothing and document how each item was removed
- Avoid cleaning or decontaminating any part of the scene or the patient's body unless it is cleaned to facilitate clinical treatment
- Preserve non-medical items attached to the patient's body i.e., a noose or knife protruding from the body, unless removed to allow clinical treatment or for safety reasons
- Do not dispose of throw away items, such as dressings, cannulae, ECG electrodes
- Medical equipment entering the body (i.e., intravenous cannula, endotracheal tube) and devices attached thereto (i.e., intravenous fluid bags, syringes) must remain in place.

Relocation of a Deceased Person

Reportable Death

In circumstances involving a reportable death, the coroner will take control of the body of the deceased person until it is no longer required for the coronial investigation.[7] Movement of the deceased person will be co-ordinated by the QPS officers in attendance at the scene.

Non-reportable death

Release to the family's funeral director from the place of death

In circumstances involving a non-reportable death, including a death where the ambulance clinician forms a view that a *Cause of Death Certificate* **is likely to be issued within 48 hours** of the death, the clinician should advise the family that the matter is not a coronial matter, and that the family should contact a private funeral director to make any necessary arrangements to relocate the body of the deceased.[7]

To assist the family, the ambulance clinician could contact the deceased person's treating medical practitioner (e.g., General Practitioner) to arrange for a *Cause of Death Certificate* to be issued.

If the person's medical practitioner cannot be contacted, the clinician should advise the family that it will be necessary for them, or their funeral director, to contact the medical practitioner to arrange for a *Cause of Death Certificate* to be issued. The clinician should also advise the family that the matter may become a coroner's case if a *Cause of Death Certificate* is not forthcoming.[7]

Release to the Government contracted funeral director

Ambulance clinicians should be alert to the possibility that family members may not be competent to make the necessary arrangements to relocate the body of the deceased person. Factors that could hinder a family member's ability to do so may relate to the person's age, infirmity, extreme grief reaction, or poverty. In such cases, it may be necessary to contact the Government contracted funeral director to relocate the body of the deceased to its premises so that an application under the *Burials Assistance Scheme*[25] can be made, or more capable relatives can be located.[7]

In circumstances involving a non-reportable death where family members are not competent to make the necessary arrangements to relocate the body of the deceased, the QAS clinician must contact police. QPS officers are authorised to arrange for the Government contracted funeral director in the relevant Local Government Authority, to attend for this purpose.

Death During Ambulance Transport

Road transport

If a patient dies during ambulance transport, the ambulance clinician must notify the relevant QAS Operations Centre (OpCen) and seek direction regarding the facility or location to which the ambulance must be diverted. The following information should be provided to the QAS OpCen at the time of notification:

- Location at the commencement of the journey and intended destination
- Time of death and location
- Whether the death is a reportable death under the *Coroners Act 2003* (Qld)

Medical equipment which is entering or attached to the body (i.e., intravenous cannula, endotracheal tube) and devices attached thereto (i.e., intravenous fluid bags, syringes) must remain in place for the pathologist to examine.[23]

Air transport

If the death occurs during aerial transport, the pilot in command of the aircraft and the Retrieval Services Queensland (RSQ) Medical Coordinator must be immediately advised of the death and will, thereafter, determine how the flight should proceed i.e., continue to the destination or return to the referring centre.[26]

The RSQ Medical Coordinator responsible for the coordination of the patient's transfer, will report the death to police and notify the family of the patient's death.[26]

Medical equipment which is entering or attached to the body (i.e., intravenous cannula, endotracheal tube) and devices attached thereto (i.e., intravenous fluid bags, syringes) must remain in place for the pathologist to examine.

Death Outside of Queensland

In circumstances where QAS clinicians have been dispatched to attend a patient at a location that is outside the Queensland border i.e., in New South Wales (NSW), and the patient is deceased, or dies following the arrival of the QAS clinicians, the ambulance clinician must notify the Police Service in the relevant jurisdiction. Notification can be facilitated through the relevant QAS OpCen.

The ambulance clinician must verify the death, complete a *QAS Life Extinct Form*, and record all relevant details in the eARF.

Support for Family of the Deceased

Ambulance clinicians interact with family members and others that may be present at the scene and are required to inform the family and bystanders if the patient has died, and thereafter, guide the family through the steps that will follow.

The patient's death may be an expected outcome of a terminal illness, in which case family members may be prepared for the death and post-death procedures. Alternatively, the death may be sudden, unexpected, and traumatic and family members may be overwhelmed by grief, confused by that which has occurred, unaware of the process that will follow, and possibly be incapable of participating in that process due to extreme grief or other circumstances.[27]

Every person, and every family will respond differently to the news that a loved one has died. It is not possible to prescribe a single procedure for informing and supporting family members following the death of a loved one, however, the ***GRIEV_ING*** pneumonic, adapted for the pre-hospital setting, may be of assistance to ambulance clinicians when informing and supporting the family of a deceased patient.[28,29] Ambulance clinicians must also be cognisant of, and respectful towards the needs of people from a diverse range of religions, cultures and spiritualities. Refer to *Introduction to Culturally Responsive Healthcare*.

G	**Gather:** family members and others that may share a close relationship with the deceased. Ensure that all members at the scene are present, however, be cautious not to allow the group to become too large.
R	**Resources:** find a suitable room or location and utilise all resources that are available to assist the ambulance clinician. This may include the QPS officers who are in attendance, a supportive family member or friend, the family chaplain or spiritual adviser, and advice that may be sought from the QAS Mental Health Liaison Line.
I	**Identify:** the ambulance clinician must identify themselves by name and must identify the deceased by their name (not by title i.e., grandpa). Clinicians must also identify the relationship that exists between those present, and the deceased.
E	**Educate:** briefly explain to those present, the events that have occurred leading up to the death of the deceased. Avoid providing complicated or technical explanations.
V	**Verify:** that the patient has died. Be clear and use unambiguous terms such as 'dead' or 'died'. Avoid terms such as 'not here anymore' or 'no longer with us' which may confuse some family members, particularly those for whom English is a second language.
[_]	**Pause:** and allow the family members present to absorb the information that has been provided.
I	**Inquire:** if there are any questions and provide answers if it is possible to do so.
N	**Nuts & Bolts:** Offer the family an opportunity to see the patient if it is practical and appropriate to do so. **Provide information** to those present, **regarding the steps that must take place** from this point. See below 'reportable death' and 'non-reportable death'.
G	**Give:** the family contact details and information that can assist them.

Information for Family

If the death is a reportable death, it is important that family members are provided with information regarding what to expect in these circumstances. If the death is not reportable, the family may be required to contact the patient's general medical practitioner and preferred funeral director. It is therefore essential that the ambulance clinician provide the following information to the family.

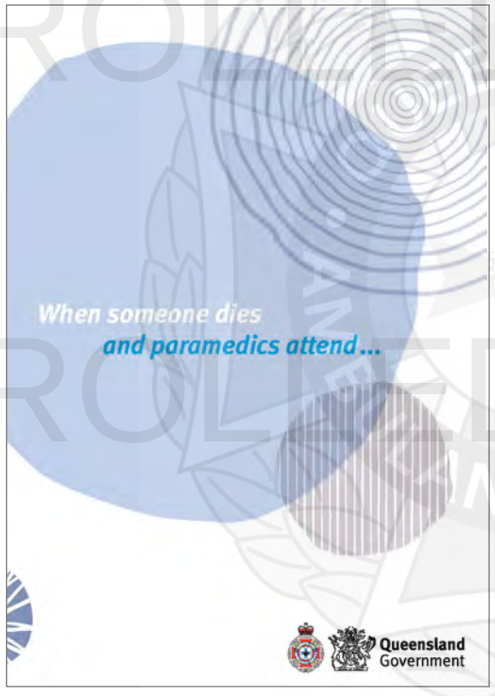
Reportable Death:

- QPS officers will attend if the patient's death must be reported to the Office of the Coroner.
- QPS will require some information regarding the patient and the circumstances leading up to their death.
- QPS officers will arrange for the Government undertaker to take the deceased to the mortuary.
- A person from the Office of the Coroner will be in contact very soon to discuss the procedures from this point.
- Provide family members with the relevant QAS card and Support Services contact details: *'When someone passes away and paramedic attend'* (First Nation's People) or *'When someone dies and paramedics attend'* (others).

Non-reportable Death:

- QPS officers are not required to attend in circumstances involving a death from natural causes, and furthermore there is no requirement to report the patient's death to the coroner.
- The attending ambulance clinician will complete a *QAS Life Extinct Form* and will leave the completed form with the family.
- The patient's general medical practitioner, or another doctor, is required to issue a *Cause of Death Certificate*. A family member should contact the doctor as soon as convenient (the ambulance clinician may contact the doctor on behalf of the family if they are contactable at that time).

- If the patient's doctor is not contactable at that time i.e., the surgery is closed, the family can contact the doctor when it is convenient to do so.
- The *Cause of Death Certificate* must be completed within 48 hours of the person's death.
- When the family is ready, they can call a funeral director of their choice. The deceased person will be taken into the care of the chosen funeral director. Ambulance Clinicians should offer to assist the family to contact the funeral director.
- Provide family members with the relevant QAS card and Support Services contact details: *'When someone passes away and paramedic attend'* (First Nation's People) or *'When someone dies and paramedics attend'* (others).



Queensland Ambulance Service Life Extinct Form

Completion of the ***Queensland Ambulance Service Life Extinct Form*** is mandatory for all cases where an ambulance clinician has verified that a patient is deceased.

1. Patient's details

Surname:	Given name(s):	
Town/Suburb:	State:	Postcode:
Date of birth:	Sex: ☐ Male ☐ Female ☐ Intersex/Intermediate ☐ Not stated/unknown	

2. Is the death reportable to the Coroner under the *Coroners Act 2003*?

*If **yes**, under which category of reportable death:*	☐ the identity of the person is unknown ☐ the death was a violent or unnatural death ☐ the death happened in suspicious circumstances ☐ the death was a health care related death ☐ cause of death certificate is unlikely to be issued (within 48 hours) ☐ the death was a death in care ☐ the death was a death in custody ☐ the death happened during, or because of police operations.
*If **no**, name of the patient's General Practitioner:*	Doctor's name: Contact number: / Practice location (suburb): Is the patient's medical practitioner likely to provide a 'Cause of Death Certificate'?: ☐ **Yes** (confirmed with Dr or practice) ☐ **Unknown** (unable to contact Dr or practice)

3. Is the death obvious?

*If **yes**, under which category of obvious death:*	☐ severe incineration ☐ rigor mortis ☐ extensive trauma ☐ hypostasis ☐ well established decomposition
*If **no**, confirm ALL of the following assessment outcomes are present:*	☐ no palpable carotid pulse ☐ no heart sounds heard for a continuous period of 30 seconds ☐ no breath sounds heard for a continuous period of 30 seconds ☐ both pupils are fixed (not reacting to light) and dilated ☐ no patient response to centralised stimuli

4. Verification of death declaration

I declare life extinct at: _____ oo:oo (24hr) on _____ DD/MM/YYYY

Ambulance clinician name:

Clinical level:
☐ Paramedic ☐ Advanced Care Paramedic ☐ Critical Care Paramedic ☐ Ambulance Medical Officer

Medal #:	Signature:

5. Additional information

QAS case number:	Queensland Ambulance Service Life Extinct Form provided to: ☐ QPS attending officer ☐ Family ☐ Uploaded to the patient's eARF (mandatory)

Brief description of events (optional):

24 hour QAS Contact: 1300 474 712 (select option 2)

Version 2.0, 18th September 2024

Classified as OFFICIAL

CPG: Clinician safety
CPG: Standard cares

Note: *Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.*

Reportable death?

N

- Notify relatives, offer condolences
- Complete *QAS Life Extinct Form*

Y

- Preserve the scene as much as possible
- Notify relatives, offer condolences
- Complete *QAS Life Extinct Form*
- Complete eARF & upload image of *QAS Life Extinct Form*
- Offer support to family members

Uncertain

Contact *QAS Clinical Consultation & Advice Line* for case specific management advice

Not reportable

Reportable or uncertain

- Assist the relatives to contact the person's treating medical practitioner (e.g., General Practitioner) to arrange a *Cause of Death Certificate* to be issued. If the person died overnight, it may be appropriate for the relatives to wait until morning if they are comfortable to do so.
- Advise family to contact funeral director of their choice. Clinician to assist as required.

If family members are not competent to make necessary arrangements (GP & funeral director)
OR
Unable to fund funeral director

- Notify OpCen
- Request QPS

Complete eARF & upload image of *QAS Life Extinct Form*