SOP Title	Death Occurring in the ED		
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V1	26rd October 2017	Mark Davies		

SOP Objectives	To ensure appropriate processes are followed for patients who die in the ED
Scope	
Performance Measures	
Related Documents	

Work Instruction – Management of patients who die in the ED		
No.	Action	Responsibility
1	All patients who die in the ED need to be referred to the Coroner. In the vast majority of cases, the coroner can be informed immediately (8.00-15.00 Monday-Friday) or the following working day	ED Consultant
2	In the out of hours period, immediate referral to the Coroner only needs to be undertaken when: • There are suspicious circumstances surrounding the death • The death is the result of significant violence • The unexpected death of a child	Senior doctor involved in the case
3	The police only need to be informed in the following circumstances • When the identity of the deceased is unknown • When support is needed in identifying, or informing the next of kin of the deceased	Resus Nursing Staff
4	In order to ensure General Office can maintain communication with the deceased relatives, a copy of the death notice must be taken by hand to General Office at the time of the death. If out of hours, it should be taken at 9am the following morning	Resus Nursing Staff
5	A note of the patient's MRN number should be made in the ED co-ordinator's diary and a note placed on the handover board so that the duty consultant can discuss with the coroner on the next working day.	Resus Nursing Staff
6	The following details must be documented in the patients notes: • Time of certification and full name and **contact details** of certifying doctor • Cause of death if known • Names and phone numbers of NOK • Names of those present when the patient died (staff and relatives)	Resus Nursing Staff
6	If a cause of death is apparent, this should be clearly documented in the notes.	Senior Doctor involved in the case
7	Communication with the coroner should be clearly documented in the clinical record	Doctor discussing with the Coroner
