SOP Title	Death Occurring in the ED		
SOP Number			
Version Number	V3		
Effective Date	February 2018		
Author	Dr Mark Davies, Clinical Director		
Approved by			
Approval date			
Distribution			
Location			

Document Control				
Version	Date	Author	Status	Comments
V1	26rd October 2017	Mark Davies		
V2	November 2017	Mark Davies		
V3	2nd February 2018	Rebecca Isles		Added nursing aspect
V4	5th May 2022	Rebecca Isles		

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	When patients die in the ED consideration needs to made regarding Coroners referral – if the cause of death is unknown, violent, suspicious, occurred in prison, custody or when detained under the MHA or is the result of injury then a referral needs to be made.	Treating Clinician
1a	If a coroner's referral is required, this should be completed by the attending clinician regardless of the time of day. 2018 (Feb) WY Coroners Service Referral Form (Review Feb 2019).docx and sending via NHS email to cah-tr.coronerreferrals@nhs.net a copy also needs to be sent to general office General.Office@cht.nhs.uk If the doctor does not have an NHS email (E.g. Locum staff) this form can be sent by another member of staff that does. Do not save the referral document on a kiosk computer desktop.	Treating Clinician
1b	If a cause of death is known then a summary of death certificate needs to be completed https://intranet.cht.nhs.uk/fileadmin/site_setup/contentUploads/Communications/Documents/Medical_Examiners_Office/summary_of_death_certification_form_-_v5.docx and emailed to medical.examiners@cht.nhs.uk	Treating Clinician
2	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
3	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)	Treating Clinician Resus Nursing Staff
4	The completion of the referral to the coroner should be clearly documented in the clinical record.	Doctor referring to the Coroner
5	The Medical Examiner will independently scrutinise the patient record and conclude regarding the nature of the death. The Medical Examiner will then contact the clinician and agree the wording for the MCCD	Medical Examiner/

	certificate. If the ED clinician is not available or unsure about the proposed cause of death the ME will discuss with the ED Consultant on duty who will then ensure the MCCD certificate is completed by an appropriate clinician.	Treating Clinician
6	The clinician will then attend General Office and complete the MCCD certificate so the death can be registered within 5 days. If the clinician cannot attend General Office during normal working hours a MCCD certificate book is available in the middle grade office in both EDs. Arrangements must then be made to get the MCCD certificate to General Office the next working day.	Treating Clinician