

# Guidelines for Verifying Death

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# Purpose

This document provides guidance on the process for verifying death. It is primarily intended for health practitioners, employers, professional bodies, the police, and the funeral industry.

The document also distinguishes the task of verifying death from related processes which ascertain and document the *circumstances* and *cause* of death:

- the completion of a Medical Certificate of Cause of Death (MCCD) by a medical practitioner or nurse practitioner, and
- when deaths are reportable to the coroner.

# Verification of death

Verification of death is the act of establishing that a person is dead and recording the time, place, and date of that assessment. Verification of death is established through clinical assessment for the absence of signs of life.

The following people are authorised by the Chief Coroner to verify death, including deaths which meet the criteria for reporting to the coroner:

- registered medical practitioners
- nurse practitioners, registered nurses, or enrolled nurses
- registered midwives
- registered paramedics
- emergency medical technicians
- police specialists (disaster victim identification / search and rescue / dive squad / maritime police specialist).

Unlike when a medical or nurse practitioner completes a MCCD (discussed below), verification of death does not have any legal status, does not require any opinion as to the cause of death, and does not constitute authority for a body to be buried or cremated.

In many settings, especially in hospitals, a medical practitioner or nurse practitioner is immediately available and able to issue a MCCD after a person dies as the explainable result of an illness.

In other situations where a medical practitioner or nurse practitioner is not immediately available to issue a MCCD, there can be potential delays for family members of the deceased. In cases where the death was expected and is explainable as the result of an illness (for example, in aged care or palliative care settings) a funeral director may remove the body providing the medical practitioner or nurse practitioner who has agreed to issue a MCCD commits to do so within the legally specified time. There is no legal requirement for death to be verified before a

body is removed. However, in many cases the funeral industry expects that a health practitioner will verify death prior to the funeral director taking over the care of the body.

In most cases, the health practitioner who verifies death and documents the assessment will be doing so at the behest of the police who are acting as the coroner's agent – because a medical practitioner is not willing to (or it is not appropriate to) issue a MCCD, and therefore the death is a coronial case (discussed below). In any case where the death is reported to the coroner, the police may prevent the body being removed, even when death is verified, in order to preserve the scene of death for further investigation.

## Assessments to verify death

A health practitioner can verify death, based on an assessment of the condition of the body when:

- the body shows signs of rigor mortis incompatible with life, or
- the body has visible injuries incompatible with life, or
- the body shows signs of decomposition incompatible with life.

Alternatively, health practitioners can verify death once they have undertaken two clinical assessments (a minimum of 10 minutes apart) to establish death. The health practitioner must confirm the following:

- no signs of breathing for one minute
- no palpable central pulse (femoral, carotid, or brachial). In most circumstances this will require palpation for 5–10 seconds
- no audible heart sounds
- pupils dilated and unreactive to light
- where available, a cardiac monitor or defibrillator is used and shows asystole.

Pathways that intensive care specialists (intensivists) and other health professionals use to verify death in the context of organ donation in New Zealand and Australia are noted on pages 5-6, below.

Health practitioners can use the coroner's form (COR31) to document the assessment and record the details of the deceased including the date, time, and place of the assessment if the death is to be reported to the coroner. The COR31 is available from the police or the Duty Coroner's office (National Initial Investigation Office) on 0800 266 800, or by emailing [niiio@justice.govt.nz](mailto:niiio@justice.govt.nz)

# Guidance for those verifying deaths

The clinical assessment described is for verifying death only. It is not to be used to determine whether or not resuscitation attempts are futile, because these two decisions are very different.

- Death must be clear and unequivocal if the condition of the body is used to verify death.
- A clinical assessment must occur if death is not clear and unequivocal.
- The entire chest and abdomen should be exposed when examining the patient for signs of breathing and this examination must occur over an uninterrupted period of one minute.
- Either the carotid or femoral site may be used when examining for a palpable central pulse. In infants aged up to one year, palpation of the brachial pulse is recommended. No duration is specified for the palpation of a pulse, but there must be certainty that the pulse is not palpable. In most circumstances this will require palpation for 5–10 seconds.
- Auscultation for heart sounds should occur over the expected site of the apex beat of the heart. In many people this will be over the fourth intercostal space in the mid-clavicular line.
- The pupils must be dilated, but no pupil size is specified. The pupils must be unreactive to light, and this requires a focal light source (e.g., a torch) to be used.
- The clinical assessment must be performed twice, with a minimum of 10 minutes between the two assessments. The reason for this is that the person may be in asystole for 5–10 minutes and then spontaneously develop return of a beating heart. This is sometimes called auto-resuscitation or the Lazarus reflex.
- It is not compulsory to determine the cardiac rhythm, but this should be done following the second clinical assessment if a suitable monitor is present.
- The person may be dead but may not be in asystole at the time of the second clinical assessment. For example:
  - there may be slow broad complexes. In this case verification of death should be delayed until asystole is present
  - a person with a pacemaker may have electrical activity generated by the pacemaker for many hours after death. In this case it is appropriate to determine the person is dead, provided all of the other clinical criteria are met.

# Verifying death in the intensive care unit in the context of organ donation

The Australian and New Zealand Intensive Care Society's (ANZICS) *Statement on Death and Organ Donation* (ANZICS 2021) provides detailed guidance for intensivists and other health professionals involved in the determination of death and in the care of potential organ and tissue donors and their families.

In summary, the Statement describes two pathways to verifying death prior to deceased organ donation.

- **Neurological determination of death (NDD)** can be determined clinically or by brain perfusion imaging, demonstrating absence of cerebral circulation. Two doctors, one of whom should be a specialist, carry out NDD and there must be definite evidence of acute brain pathology consistent with deterioration to permanent loss of all neurological function. For clinical determination, there is a minimum observation period prior to clinical examination. During this period a set of preconditions must be met. Following this period, a full clinical examination according to the ANZICS Statement is performed by each doctor to confirm the absence of all brainstem reflexes and breathing effort.
- **Circulatory determination of death** requires the absence of spontaneous movement, breathing, and circulation. Absence of circulation is evidenced by absent arterial pulsatility for 5 minutes using intra-arterial pressure monitoring and confirmed by clinical examination. Rarely, in cases without an arterial line, electrical asystole should be observed for 5 minutes on the electrocardiogram and confirmed by clinical examination.

For either of these pathways, standardised ANZICS forms are completed for death declaration (ANZICS 2021).

## Medical Certificate of Cause of Death

Completion of the MCCD on an HP4720 form (or HP4721 for deaths of babies within 28 days of birth), is separate to and completely different to the process for verifying

death. The MCCD is a legal document which records the full details of the deceased, the circumstances of and cause of death. It can only be completed by a medical practitioner or nurse practitioner.

If a person has died after an illness, section 46B of the Burial and Cremation Act 1964 requires that a MCCD is issued by a medical practitioner or nurse practitioner within 24 hours of the health practitioner learning of the death, provided they are satisfied that the cause of death was the result of an illness and is not otherwise reportable to the coroner.

Section 46C allows a medical practitioner or nurse practitioner to complete an MCCD for a person aged 70 years or more who has died as a result of accidental injuries, where the accident arose due to infirmities attributable to the deceased's age.

The MCCD is required before a body can be embalmed, buried, or cremated. It must not be issued for a death reportable to the coroner (discussed below).

### **Stillbirth**

Section 46A of the Burial and Cremation Act 1964 outlines who can sign the Medical Certificate of Causes of Fetal and Neonatal Death (HP4721) with regard to a stillbirth.

Stillbirth is defined in the Births, Deaths Marriages and Relationships Registration Act 2021 as meaning “the issue of a stillborn child from its birth mother”. The term **stillborn child** means: “a dead foetus that—

- (a) weighed 400 g or more when it issued from its birth mother; or
- (b) issued from its birth mother after the 20th week of pregnancy”.

In most cases of stillbirth a medical practitioner will sign the Medical Certificate of Causes of Fetal and Neonatal Death. However, where a medical practitioner was not present at the birth or did not examine the baby, a midwife can sign to expedite burial or cremation.

### **Further information**

Medical practitioners and nurse practitioners can complete the MCCD (HP4720) online on the [Death Documents](https://deathdocs.services.govt.nz) website (<https://deathdocs.services.govt.nz>).

More information on completing a MCCD, and other death documentation, is also available at: <https://www.tewhatauora.govt.nz/health-services-and-programmes/burial-and-cremation-act-1964/completing-death-documents/>

# The role of the coroner

The role of the coroner is to investigate reportable deaths to establish why, where, when, and how the death occurred. The aim of the investigation is to establish the facts and to work out whether anything can be done differently to prevent future deaths in similar circumstances. Around 14% of deaths in New Zealand each year are reported to the coroner, and around 10% (of total deaths) are accepted into the coroner's jurisdiction each year.

## Reportable deaths

Deaths reported to the coroner are defined in section 14 of the Coroners Act 2006 and are:

- deaths which are without known cause, self-inflicted, unnatural, or violent. In summary, unnatural deaths can include accidents, homicide, suicide, violent death, falls, poisoning or overdoses (intentional and unintentional) and drowning
- deaths for which no Medical Certificate of Cause of Death under section 46B or 46C of the Burial and Cremation Act 1964 has been given
- a death that occurred during, or that appears to have been as a result of, a medical procedure and that was medically unexpected. The term medical procedure (defined in section 9) means a medical, surgical, or dental treatment or operation, or any procedure of a similar kind and includes the administration of a medicine (as defined in [section 3](#) of the Medicines Act 1981) or an anaesthetic
- a death that occurred while the person concerned was affected by an anaesthetic and that was medically unexpected
- a death that occurred while the person concerned was giving birth, or that appears to have been the result of that person being pregnant or giving birth
- deaths in official custody or care, including any person who died while subject to the following Acts:
  - (a) a patient within the meaning of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (whether or not the death occurred in a treatment centre):
  - (b) a child or young person who has been placed in a residence within the meaning of section 2(1) or 364 of the Oranga Tamariki Act 1989 (whether or not the death occurred in the residence):
  - (c) a child or young person who—
    - (i) is in the custody or care of an iwi social service, a cultural social service, a residential disability care operator, or the director of a child and family support service pursuant to section 43, 78, 101, 102, 110, 139, 140, 141, 142, 234, 238, or 345 of the Oranga Tamariki Act 1989; or

- (ii) is in the charge of any person or organisation pursuant to section 362 of that Act:
- (d) a patient within the meaning of section 2(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (whether or not the death occurred in the hospital concerned):
- (e) a care recipient or proposed care recipient within the meaning of section 5(1) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (whether or not the death occurred in the facility concerned):
- (f) a prisoner within the meaning of section 3(1) of the Corrections Act 2004 (whether or not the death occurred in the prison concerned):
- (g) a person in the custody of the New Zealand Police:
- (h) a person under the control of a security officer (as defined in section 3(1) of the Corrections Act 2004):
- (i) a resident within the meaning of section 3 of the Public Safety (Public Protection Orders) Act 2014.

## Reporting deaths to the coroner

While some deaths must be reported to the coroner, deaths which are expected and explainable do not. A death does not need to be reported to the coroner when a medical practitioner or nurse practitioner agrees to issue a Medical Certificate of Cause of Death (MCCD), provided that the death is not otherwise reportable under sections 13 and 14 of the Coroners Act 2006. In such cases, the provisions of Section 46B of the Burial and Cremation Act 1964 apply.

Section 13(1) and (2) of the Coroners Act 2006 requires that any person who finds a body in New Zealand or learns of a death to which section 14 of the Coroners Act 2006 applies must report the finding to the police. A pragmatic interpretation of the Act means that a person finding a body where the death is expected and explainable and occurs in a setting such as aged care or palliative care, does not need to report finding the body to the police. However, in any sudden, unexpected death where the body is found and the cause of death is not established, including if a person is found dead at home, the police should be notified. It is the role of the police to determine whether the death is reported to the coroner.

Section 13(1) and (2) does not apply in any case in which the death was a result of assisted dying under the [End of Life Choice Act 2019](#) (section 13(2A) of the Coroners Act 2006 refers).

Where there is any doubt, the National Duty Coroner can determine whether a death is classified as reportable. Telephone 0800 266 800.

Medical practitioners and nurse practitioners can now use the government digital tool [Death Documents](https://deathdocs.services.govt.nz) (<https://deathdocs.services.govt.nz>) to report a death to the coroner if the deceased was 28 days of age or older at the time of death. The online report form asks a series of screening questions to guide the practitioner through the reporting requirements then provides a recommendation to either complete and submit a Coroner Report or complete a MCCD (because the death does not need to be reported to the coroner).

To report the death to the coroner of a baby less than 28 days of age, in hospital, complete a Hospital Record of Death (HROD) form and phone the Duty Coroner on 0800 266 800.

Information for doctors and nurse practitioners on when and how to report a death to the coroner is available at: <https://coronialservices.justice.govt.nz/information-for-doctors-and-nurse-practitioners/>

More information about coronial services is available at: <https://coronialservices.justice.govt.nz/coronial-services/>

## Education and practice support systems

Registered medical practitioners, nurse practitioners, registered nurses, enrolled nurses, registered midwives, emergency medical technicians, registered paramedics and police specialists (Disaster Victim Identification / Search and Rescue / Dive Squad / Maritime Police Specialist) are authorised by the Chief Coroner to verify death. The required technical expertise and skill is within these health practitioners' scopes of practice.

Alongside technical expertise it is important health practitioners understand the legislation that guides their practice. In particular, when verifying death, health practitioners must have a thorough understanding of the Health Practitioners Competency Assurance Act 2003, and the implications for practice in the Code of Health and Disability Services Consumers' Rights<sup>1</sup>, the Coroners Act 2006, the Burial and Cremation Act 1964, Births, Deaths Marriages and Relationships Registration Act 2021, and the codes of ethics and professional boundaries for their practice.

Employers and organisations have a role to ensure health practitioners are supported to verify death through clinical governance systems which cover policy, professional development and clinical leadership.

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<sup>1</sup> <https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/>

Collaborative relationships between health practitioners in local areas will support a seamless service and promote best practice, whilst ensuring professional boundaries are well known and understood. It is essential that the Police, funeral directors, health practitioners and health care facilities establish well understood roles, responsibilities, and pathways for responding to deaths.

## Opt out decision

Health practitioners are required by the Health Practitioners Competence Assurance Act 2003 to only undertake those activities within their scope of practice and for which they have the required competence. While the competencies for verification of death are included within the named groups of health practitioners' scope of practice, and the activity undertaken as part of their usual roles, verification of death is **voluntary**. Any health practitioner who is not willing or does not feel competent to undertake the activity can defer to another health practitioner.

## Role of the funeral director

The funeral director is employed by the family of the deceased after the death to provide advice and services for the family including:

- transport of the body
- registering the death
- meeting the legal requirements for burial or cremation (including bookings for a cemetery or crematorium, and filing the necessary forms for cremation)
- the embalming, care and presentation of the deceased's body
- placement of death notices and/or funeral notices in the paper
- the funeral service.

In cases where the death was expected, for example, in aged care and other palliative settings, the funeral director may remove the body before the MCCD is issued. In such cases, the medical practitioner or nurse practitioner who has agreed to issue the MCCD must do so within the legally specified time. In all cases, the funeral director must **receive** a completed MCCD from the medical practitioner before a body is embalmed, buried or cremated.

Where the death was reported to the coroner, the funeral director must not remove the body until they have received written authorisation from the coroner to do so under section 42 of the Coroners Act 2006.

Many families choose to arrange the funeral themselves without the services of a funeral director. The family is also then responsible for taking care of the legal requirements. Community Law NZ provides guidance around this on its website.<sup>2</sup>

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<sup>2</sup> <https://communitylaw.org.nz/community-law-manual/chapter-16-a-death-in-the-family/a-death-in-the-family/>

# Reference documents

Births, Deaths, Marriages and Relationships Registration Act 2021.

<https://www.legislation.govt.nz/act/public/2021/0057/latest/whole.html>

Burial and Cremation Act 1964

<https://www.legislation.govt.nz/act/public/1964/0075/latest/whole.html>

Coroners Act 2006.

<https://www.legislation.govt.nz/act/public/2006/0038/latest/whole.html>

End of Life Choice Act 2019.

<https://www.legislation.govt.nz/act/public/2019/0067/latest/DLM7285905.html?src=qs>

Health Practitioners Competence Assurance Act 2003.

<https://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>

Nursing Council of New Zealand. 2012 (reformatted 2022). *Competencies for enrolled nurses*.

[https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Enrolled\\_nurse.aspx?hkey=963854c0-246c-4bb1-800c-920a19b022dc](https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Enrolled_nurse.aspx?hkey=963854c0-246c-4bb1-800c-920a19b022dc)

Nursing Council of New Zealand. 2016 (reformatted 2022). *Competencies for registered nurses*.

[https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Registered\\_nurse.aspx?hkey=57ae602c-4d67-4234-a21e-2568d0350214](https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Registered_nurse.aspx?hkey=57ae602c-4d67-4234-a21e-2568d0350214)

Nursing Council of New Zealand. 2017. *Competencies for the nurse practitioner scope of practice*.

[https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Nurse\\_practitioner.aspx?hkey=1493d86e-e4a5-45a5-8104-64607cf103c6](https://www.nursingcouncil.org.nz/Public/NCNZ/nursing-section/Nurse_practitioner.aspx?hkey=1493d86e-e4a5-45a5-8104-64607cf103c6)

Midwifery Council. 2007. *Competencies for entry to the register of midwives*.

<https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Registration/Competencies%20for%20entry%20to%20the%20Register.pdf>

The Australian and New Zealand Intensive Care Society. 2020. *Statement on Death and Organ Donation*. Melbourne. Edition 4.1 2021. ISBN 4978-1-876980-39-9.

<https://www.donatelife.gov.au/sites/default/files/2022-01/anzics-statement-on-death-and-organ-donation-4.1.pdf>

# Related websites

Births Deaths and Marriages – Whānautanga, Matenga, Mārenatanga:

<https://www.govt.nz/organisations/births-deaths-and-marriages/>

Community Law New Zealand

<https://communitylaw.org.nz/community-law-manual/chapter-16-a-death-in-the-family/overview-3/>

Coronial Services of New Zealand – Purongo te Ao Kakarauri:

<https://coronialservices.justice.govt.nz/coronial-services/>

Death Documents: <https://deathdocs.services.govt.nz/welcome>

End of Life Services – Te Hokinga ā Wairua: <https://endoflife.services.govt.nz>

Health New Zealand – Te Whatu Ora: <https://www.tewhatauora.govt.nz/health-services-and-programmes/burial-and-cremation-act-1964/>

Organ Donation New Zealand: <https://donor.co.nz/>

Australian Government Organ and Tissue Authority: <https://www.donatelife.gov.au/>

Australian and New Zealand Intensive Care Society: <https://www.anzics.org/>