HM Government

Managing the Deceased During a Pandemic

Guidance for planners in England

March 2020

Contents

Part 1 - Introduction

Aim

1.1 The purpose of this document is to provide advice to local planners in England on ways to augment their collective capacity to manage the deceased when their normal capacity and capability could be overwhelmed. The Devolved Administrations lead on excess deaths planning in Scotland, Wales and Northern Ireland.

Objectives

1.2 A severe pandemic is the incident most likely to create a need for an excess deaths capability. During a pandemic, there is potential for a significant increase in the number of deaths in a relatively short period of time placing pressure on local service providers with responsibilities relating to managing the deceased. By their nature, it is difficult to predict the severity of such events and the impact of health interventions and other mitigation measures.

1.3 For this reason, measures and processes to manage the deceased during a pandemic will need to be scalable. All planning should be guided by the following four strategic objectives:

- The death management process must have the capacity to continue to operate under the pressure of a large number of excess deaths while maintaining the welfare of staff;
- Any new measures and working arrangements introduced to manage the deceased should ensure an appropriate level of dignity and respect is maintained;
- The bereaved should be treated with care and compassion and their wishes for the deceased be respected wherever possible; and
- There should be clear and consistent communications to inform and engage with service providers and the public to ensure that plans are well-known and approved by all relevant stakeholders.

Roles & Responsibilities

1.4 The local capability to manage excess deaths comprises individual organisations' plans in support of a multi-agency plan held at Local Resilience Forum (LRF) level.

1.5 It is the responsibility of all those involved to ensure that their plans and associated actions are lawful. With this in mind, local service providers are expected to participate as fully as possible in LRF planning.

1.6 ***Local Resilience Forums (LRF) -*** Local Resilience Forums are the principal

mechanism for the coordination of multi--agency planning at the local level. Whilst LRFs' constituent members are responsible for planning within their own organisations, as an entity, the LRF is responsible for ensuring there is an effective, fully coordinated capability in place across the LRF area. It is recommended that LRFs have a dedicated group focused on excess deaths planning with representation from all public and private organisations with responsibilities for managing the deceased.

1.7 ***Local authorities*** **-** As Category 1 responders, local authorities[1] have a duty under the Civil Contingencies Act 2004 (CCA 2004) to maintain and publish plans to reduce, control or mitigate the effects of an emergency, including those such as pandemics which can cause large scale loss of human life, and to cooperate and share information to work together effectively.[2] Local authority business continuity plans should cover those aspects of the death management process for which they have responsibility including death registration; the funding and staffing of coronial services within their areas; the disposal of the deceased where no other parties are available; and maintaining and operating public mortuaries, cemeteries and crematoria. Local authorities also have responsibility for the removal and transport of the deceased under Public Health legislation and they provide coroner services.

1.8 In addition, the CCA 2004 requires local authorities to take steps to provide advice and assistance to organisations in their area relating to their business continuity. This duty relates primarily to Small-Medium Enterprises and the voluntary sector, but local authorities should also ensure the businesses they depend on have effective business continuity plans. For excess deaths, this is particularly important for those business areas which perform a function of the death management process, including private cemeteries, crematoriums and funeral directors.

1.9 ***National Health Service (NHS) England*** **-** As a Category 1 responder, NHS (England) have a duty under the CCA 2004 to maintain and publish plans to reduce, control or mitigate the effects of an emergency. Their main focus will remain on treatment and care for the living during a pandemic but in order to keep the excess deaths capability working, all medical practitioners including general practitioners are responsible for certifying cause of death and completing the Medical Certificates of Cause of Death (MCCDs). NHS trusts are also responsible for contingency plans for maintaining sufficient hospital mortuary capacity. In some areas, there are no council-owned public mortuaries and all local provision is through NHS mortuaries. This arrangement does not affect local capacity, but it is relevant to governance.

1.10 ***Other local service providers*** **-** Alongside the services provided by public

[1] Local authorities include county councils, district councils, London borough councils, the Common Council of the City of London, the Council of the Isles of Scilly, and County Borough Councils.

[2] https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others

organisations, the private sector and faith institutions play a crucial role in managing deaths. An essential part of LRF planning will be to bring these groups together. Local service providers will be responsible for putting in place their own business continuity plans and assurance measures but can also contribute to the LRF plan. It is vital these organisations are engaged at the earliest opportunity during the planning process. They are however not legislatively bound to assist.

1.11 ***Individuals and next of kin*** **-** It is the responsibility of individuals to make arrangements for their own funeral. If individuals die intestate, the responsibility falls first to the next of kin, and then to the local authority under Section 46 of the Public Health (Control of Disease) Act 1984.

Assurance

1.12 Part 1 of the CCA 2004 places a legal obligation on Category 1 responders collectively to assess the risk of, plan for, and exercise for emergencies, as well as ensuring they have BCPs to maintain their key services.

1.13 As with any contingency plan, organisations should have in place a thorough testing and exercise regime for their plans and procedures. This should be complemented by a regular programme of review and validation.

Part 2 - Preparing

Preparing to manage Excess Deaths

2.1 Responding to an excess deaths scenario will require a high degree of coordination to ensure that the local death management capability can meet the demands placed on it. Central Government crisis management arrangements will be activated to coordinate the government's response, provide strategic direction and support to local responders as appropriate.

2.2 An LRF's excess deaths management capability will comprise local plans held by its constituent members, plus an LRF level plan covering the coordination of individual local plans, deployment of LRF resources and arrangements to fill gaps in local capability. The LRF plan will also show how local Command, Control and Coordination (C3) arrangements connect to those for Central Government. The LRF will want to be assured there are plans in place to cover each of the elements of the death management process.

2.3 Local excess deaths plans should reference how external indicators such as those produced by the World Health Organisation (WHO) and Public Health England (PHE) might act as triggers or thresholds. Plans should also reflect the way pandemics can grow in severity and how this relates to response options, including those requiring Central Government action.

Engagement with Local Service Providers

2.4 Private sector organisations including funeral directors, private crematoria, cemeteries and burial grounds play a significant role in local death management. Whilst such organisations are not responders under Part 1 of the CCA 2004, they are a key resource and should be engaged locally when developing contingency plans while recognising there may be limitations imposed by competition law. Where there is a dependency on a private sector organisation within local plans, care should be taken to inform these entities of their roles and responsibilities and guarantees of provision of service if the plans are implemented, paying particular attention to whether they already hold such agreements with other geographical areas.

2.5 The baseline for all multi-agency work on excess deaths is knowing the local capacity of the funeral industry and the trigger for instigating wider arrangements to support them, in order to maintain services in a scenario of increased demand. It is therefore recommended that the local funeral sector is represented on excess deaths planning groups in each LRF so that these arrangements can be fully integrated into the plan.

2.6 The faith sector also plays an important part in the death management process and in providing support to the bereaved. Engagement with the sector in excess

deaths planning is crucial.

Planning Process

2.7 Plans to manage excess deaths should comprise a range of measures which may augment capacity at all stages of the death management process. A list of the type of measures which may be considered is set out in each stage below. Most will be for individual organisations to develop and implement as required, but some will require coordination at LRF level, or changes to regulations which can only be made by Central Government.

Transport of the Deceased

Background

2.8 Body transport is normally undertaken by funeral directors, with NHS ambulances, private ambulances and hospital porters taking up a smaller share. There is no regulation placed on any member of the public transporting a body, although it is advised that the local police are informed if a body is to be moved by a non-professional service. Body transport could be from place of death to a mortuary for coronial investigation, from or to a body storage facility, or directly to the place of body disposal.

2.9 While there is a low risk of infection from the deceased during transport, there is the potential for the deceased's family or friends engaging with body transport providers to become infected.

Legislation, Regulation and Guidance to Consider

2.10 **Health and Safety at Work Act 1974** places a duty to manage risks arising from work activities to protect the health and safety of employees, so far as is reasonably practicable. Specific areas of interest apply to the risks of infection that may arise from work activities and injuries that may result from manual handling.

2.11 **Management of Health and Safety at Work Regulations 1999** provides a broad framework for managing health and safety at work. This extends to a responsibility for employers sharing work premises to coordinate and cooperate.

2.12 Because employees of differing organisations are involved during the transportation of the deceased, there must be an adequate and appropriate exchange of information on risk between the involved parties at different stages. This information is required to complete a suitable and sufficient risk assessment, leading to the effective control of infection risks from the deceased.

2.13 Conventional health and safety issues likely to arise from the transportation of bodies in large numbers include:

- Manual handling – consideration will need to be given to use of mechanical

lifting aids to reduce the risk of injury from the moving and handling of bodies. This should include an understanding of specialized equipment available for the lifting and moving of bariatric bodies;
- Temperature – working in cold stores for prolonged periods will require appropriate Personal Protective Equipment (PPE); and
- Psychological impact of the work – appropriate support or direction should be made available to those working with the deceased particularly if this is not their normal role.

2.14 **Control of Substances Hazardous to Health (COSHH) Regulations 2002** provide a framework of actions designed to control the risk from a range of hazardous substances, including infectious micro-organisms (defined as 'biological agents' within COSHH). The COSHH Regulations deal with the selection, training and use of suitable PPE and/or Respiratory Protective Equipment (RPE).

2.15 **Health and Safety Executive (HSE) Guidance on Managing Infection Risks when Handling the Deceased** states when transporting the deceased, with a known infection risk, or where there is significant leakage of body fluids, or significant deterioration, a body bag will minimise the potential for exposure of workers and contamination of the vehicle. If the body bag has been used to control the risks of infection, there is a requirement to indicate this on a completed hazard notification sheet which should accompany the body at all times.

2.16 If a body bag is unavailable for any reason, other wrapping will have to be used which may be less effective at capturing body fluids, therefore use of suitable PPE to protect workers and prevent contact with body fluids will be essential, along with standard hygiene/infection control precautions.

2.17 Standard infection control precautions for funeral service staff and other staff during delivery or removal of the deceased are recommended. These consist of:

- Refraining from smoking, eating, chewing, drinking or doing anything else that will bring the handler's hands into contact with their mouth, eyes or nose;
- Making sure that any cuts or abrasions, particularly on the handler's hands, are covered by a waterproof dressing. If there is any doubt about the effectiveness of the cover, obtain medical advice;
- Making sure single-use protective gloves and aprons are readily available and handlers are trained as to when to wear and remove them; and
- Making sure disinfectant, swabs and cloths are available and used in order to clean handlers and their vehicles safely.

2.18 There are four main sources of infection that should be considered when handling the deceased:

- Blood and other body fluids (e.g. saliva, pleural fluids);

- Waste products, such as faeces and urine;
- Aerosols of infectious material, which may be released when moving bodies or handling organs/tissue samples; and
- Direct contact with tissues (e.g. skin).

2.19 There will be a need to carry out risk assessments to decide on selection of suitable PPE to protect those handling the deceased, dependent on the condition of the body and whether it presents a microbiological risk, e.g. masks and visors. A precautionary approach is advisable e.g. agreeing a standard PPE ensemble before implementation.

2.20 Disinfection and cleaning of vehicles used to transport the deceased, in order to control secondary infection from body fluids, will be essential.

Roles & Responsibilities

2.21 In the event of an excess deaths scenario, the movement of bodies between homes, hospitals, mortuaries and body storage and disposal sites will require significant transportation and manual handling capacity. Vehicles used for the transportation of the deceased are not currently subject to any certification; however, care should be taken to ensure, as far as is possible, that vehicles are appropriately adapted to avoid any practical religious or ethical issues arising. Funeral directors can advise on an appropriate specification.

2.22 The cost of transportation of the deceased should be met by family members or, if the deceased have no family members willing or capable to arrange a funeral, the local authority. The local authority will also meet the costs of the Coroner related transportation costs.

2.23 The following organisations may have suitable vehicles and/or drivers which can be used for body transportation:

- Funeral directors;
- Private ambulance providers;
- Police forces;
- Local authorities;
- Commercial transport companies;
- Short-term vehicles hire companies; and
- Local military (requested through the usual Military Aid to the Civil Authorities (MACA) process)

Members of the deceased's family may also be prepared to assist.

2.24 In determining what transport options are available, consideration should be given to the availability of suitably experienced, equipped and trained drivers, plus a clear specification setting out what is required and how it will operate.

2.25 Ambulance services are responsible for providing a health service for patients or casualties. Once the 'recognition of life extinct' procedure has concluded, the NHS Ambulance Service has no responsibility for management of the deceased. During a pandemic, NHS Ambulance Services will not have the capacity to support the removal or transportation of bodies.

Measures for Augmenting Local Capacity

2.26 If the requirement for body transportation is expected to exceed normal capacity, other measures which planners may consider are:

Measures for Augmenting Local Capacity	Local Lead	Planning Notes
Arrangements to coordinate the procurement and staffing of body transport, and movement of all bodies.	Local authority or LRF	LRFs should consider establishing a Body Transport Coordination Cell to ensure plans are in place for effective arrangements for body transport, possibly as part of a wider excess deaths coordination sub-group of the Strategic Coordination Group (SCG).
Use of alternatives to coffins (e.g. body bags) to facilitate transport.	Local planners	Options should be included and detailed in LRF plans. Options for procuring supplies of such alternatives should be evaluated locally. Potential health and safety considerations.
Augment capacity in the local funeral director sector with voluntary or public sector staff.	Local authority	Options should be included and detailed in LRF plans.

Medical Certificate of Cause of Death (MCCD)

Background

2.27 In a non-emergency scenario when someone dies in England it is a requirement that a medical practitioner or coroner certifies the cause of death. This confirmation is exhibited in an official document called the Medical Certificate of Cause of Death (MCCD). There is a statutory duty on the medical practitioner who has 'attended the deceased during their last illness' to complete a MCCD. If this is longer than 14 days prior to the death then the medical practitioner must view the deceased. If the medical practitioner has not viewed the deceased within 14 days prior to death or after death then the registrar will refer the case to the coroner.

2.28 The doctor completing the MCCD will specify the cause of death and not the fact. The concept of 'life extinct', i.e. the fact, can be declared by a doctor, a police forensic medical examiner, or suitably qualified clinicians and paramedics.

2.29 In some circumstances, a medical practitioner is unable to certify the cause of death and the death must be reported to the Coroner, rather than issuing a MCCD. Such circumstances include when the death was deemed violent, unnatural, in state detention or of unknown cause.

2.30 Each death in custody or state detention in England and Wales (except those subject to Deprivation of Liberty Safeguards) is subject to an inquest by the Coroner. Prisons and Detention Centres in England have contractual health care provided by the NHS, providing them with a designated resource. Prisoners also have a high rate of dependency on the health service. Early conversations, at a local level, with medical practitioners operating within the custody facilities should establish the processes by which a satisfactory cause of death can be produced for the coroner as efficiently as possible, should a prisoner's or detainee's death have been obviously caused by a pandemic.

Legislation, Regulation and Guidance to Consider

2.31 **The Coroners and Justice Act 2009** makes reference to a medical examiner system to scrutinise all non-coronial deaths. A non-statutory medical examiner system was introduced from April 2019 however the medical examiner system is not yet a statutory requirement. In a period of emergency it is recommended that a medical examiner system is suspended and medical examiners revert to their usual duties as a medical practitioner, thereby adding to the medical practitioner resource required to complete MCCDs.

2.32 **Pandemic Influenza: Guidance on the management of death certification and cremation certification** states the completion of a MCCD must be distinct from verification that a person has died. Such verification allows the body to be moved from the place of death to a mortuary, body storage facility or the premises of a funeral director once suspicious circumstances have been excluded.

2.33 Efficient verification of 'life extinct' is important for ensuring an effective and seamless process towards disposal. Deceased persons should not be taken to hospital for verification of death. Local consideration should be given to making sure there is clear agreement on which individuals, and in which circumstances, can verify death.

Roles & Responsibilities

2.34 During a pandemic, all medical practitioners including general practitioners are responsible for completing MCCDs and certifying the cause of death.

2.35 NHS planners have a responsibility to work with doctors to ensure that local plans are put in place to cope with the increased need for MCCD provision. Additionally, NHS planners should agree with the emergency services in their area how to sustain or augment arrangements when someone dies away from a hospital setting. Plans should include arrangements for sensitively explaining how normal arrangements may have changed to families of the deceased and ensuring these are understood.

Measures for Augmenting Local Capacity

2.36 If the national situation is so adverse that there is little or no scope for mutual aid

arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.37 Key measures for local planners to note are listed below:

Measures for Augmenting Local Capacity	Local Lead	Planning Notes
Extension of doctor working hours.	NHS	Should be included and detailed in local NHS and LRF plans. Consideration should be given to any Working Time Directive restrictions.
Remove the requirement for sick notes to be provided by doctors to allow them to focus on healthcare and MCCD sign off.	Local employers	Should be included and detailed in LRF plans. Discretion already exists within the Statutory Sick Pay Medical Evidence Regulations to allow employers to be flexible around when they ask for medical evidence. The requirement was suspended during the 2009 flu pandemic.
Use of primary legislation to allow retired medical practitioners still registered with the General Medical Council to certify deaths.	NHS	LRFs should consider this as a potential measure to be reflected in their excess deaths plans. Central Government will notify local planners if and when such a provision was being introduced.
Primary legislation to allow medical practitioners who have not attended deceased during final illness to provide an MCCD if their death appears, to the best of their knowledge, to have been caused by natural causes.	NHS	LRFs should consider this as a potential measure to be reflected in their excess deaths plans. Central Government will notify local planners if and when such a provision was being introduced.
Secondary legislation to allow attending practitioners (where possible) to complete an MCCD without a referral to the Coroner as long as they have seen the deceased within 28 days rather than the current 14 days.	NHS	LRFs should consider this as a potential measure to be reflected in their excess deaths plans. Central Government will notify local planners if and when such a provision was being introduced.
Put arrangements in place to be able to deal with the increase in deaths at home and the signing of MCCDs.	NHS	Should be included and detailed in local NHS and LRF plans.
If it would be useful for nurses who do not normally confirm life extinct to do so in a pandemic, appropriate training should be provided to ensure that the nurses concerned consider themselves competent to perform this role.	NHS	Should be included and detailed in local NHS and LRF plans.
Doctors who are no longer registered with the General Medical Council (GMC) may still be able to assist in certifying death or acting as a medical referee, acting responsibly within the scope of GMC guidance on responding to emergencies. This type of registration is called Temporary Registration (Emergency) (TR(E)). TR(E) will be covered by NHS indemnity insurance arrangements providing there is a clear contractual relationship with an employer.	NHS	Should be included and detailed in local NHS and LRF plans.

Coroners

Background

2.38 A Coroner is an independent judicial officer appointed by local authorities with the consent of the Chief Coroner and Lord Chancellor. Most Coroners are qualified lawyers but some Coroners may be doctors. All are judges. Coroner's Officers, who may be civilians or police officers, work under the direction of the Coroner and liaise with bereaved families, the police, doctors and funeral directors.

2.39 Coroners have a statutory duty to investigate deaths reported to them when there is reason to suspect the death may have been violent or unnatural or violent, of unknown cause or in custody or otherwise in state detention. Local authorities and the police provide funding for resources and staff to support the Coroner.

Legislation, Regulation and Guidance to Consider

2.40 **Registration of Births and Deaths Regulations 1987** states that a death must be referred to the Coroner if the medical practitioner (who attended the deceased during their final illness) did not see the patient within 14 days prior to the death or after death. In a period of emergency, it is intended that the 14 day period is extended to 28 days and that any medical practitioner can certify the cause of death by completing the MCCD if they or any other medical practitioner has attended the patient within 28 days prior to death, verified the death or viewed the deceased.

2.41 The Chief Coroner will issue guidance as necessary to coroners on matters relevant to pandemics and similar. It will cover, for example, the recruitment of additional judicial resources as well as a range of practical matters.

2.42 In general, the LRF should discuss the likely demands on coroners and their staff; the Coroner's own staff shortages in a pandemic; and the scope for flexible working, including distance working, and arrangements for the pooling of resources. Coroners will need robust business continuity plans, and these could usefully be included in the wider LRF plans. The issues before the coroner will have an inevitable and significant overlap with questions of body storage, transport of bodies and so on, in an excess deaths scenario.

2.43 In a pandemic scenario, there may be a proportion of deaths that will be reported to the Coroner which, in normal times, would be registered through the MCCD route, but cannot be because the deceased has not been seen by a doctor within the legal timescales. LRFs and the local coroner should engage in planning for the scenario.

2.44 Where a death is reported to the coroner, it is for the coroner to determine whether a post-mortem examination is necessary, or whether the cause of death can be established on the basis of other evidence. Coroners are reliant upon

hospitals and local authorities for the provision of post-mortem examination facilities. It is also important to understand that such mortuaries will be handling a significant number of deceased associated with the pandemic and therefore there will be a substantial reduction in the available capability of mortuaries, pathologists and mortuary staff to process even the normal throughput of cases. Coroners should always consider, in all circumstances, whether a post-mortem examination is necessary, particularly where a post-mortem examination may be judged a high risk.

2.45 Coroners are required to investigate deaths that occur abroad where the body is returned to their jurisdiction and the circumstances of the death are such that they would otherwise be required to investigate if the death had occurred in England. In the event of a pandemic there may be an increased number of deaths abroad that would need to be referred to the Coroner where the body is repatriated. During a pandemic the appetite for processing these should be weighed against the needs to keep the Coronial system as efficient as possible. It is not the role of the coroner to manage the repatriation, only to deal with the case once it is reported to them.

Roles & Responsibilities

2.46 In prioritising local services in the event of a pandemic, local planners should take into account the key role the Coroner plays in ensuring a smooth death management process. Were there any disruption to Coroner's services locally, the potential for disruption and impact on public health would be considerable.

2.47 Coroners have a pivotal role in relation to post-mortems and the numbers that are carried out. Coroners should, therefore, be an integral part of the planning and response process, feeding their views into the overall LRF Pandemic plan. Local authorities should work with Coroners and local police to put business continuity plans in place. These should include arrangements for explaining to families of the deceased any changes to the normal working procedures and practices, and ensuring these are understood.

Repatriation Overseas

2.48 As with many of the procedures around death and funerals, repatriation of human remains is essentially a private arrangement between the family of the deceased and one or more commercial organisations. Nevertheless, in cases where repatriation is desired, the body cannot leave England or Wales without the authorisation of the coroner.

2.49 During a pandemic, repatriation may be difficult due to circumstances at the time in other countries and possible flight disruption. The Foreign and Commonwealth Office (FCO) can inform foreign missions in the UK that it may not be possible for repatriation of bodies of foreign nationals to continue in the event of a pandemic, and that local body disposal is the more likely course. Similarly, it is not possible to predict whether other countries will continue to permit repatriation of British

Nationals during a pandemic.

Measures for Augmenting Local Capacity

2.50 Local authorities, coroners and others within the LRF should identify measures they might take to ensure coronial services can be maintained. There will be considerable overlap between narrower coroner issues and wider issues of body storage, body transport, mortuary capacity etc. Should capacity to maintain services reduce, coroners' (and related) business continuity plans should identify what their priorities will be during a pandemic. These plans should include arrangements for explaining to families of the deceased the situation and ensuring these are understood. They should also be shared with LRFs.

2.51 The following business continuity measures should be considered by Coroners and local authorities and included in business continuity planning:

- Deploy judicial and other resources efficiently - it may for example, be necessary to prioritise decision-making on report of death rather than hearing inquests;
- Identification of potential additional judicial resources which can be appointed in the event of a pandemic;
- By agreement between Coroners and their local authorities, neighbouring coroner's areas may volunteer to pool resources;
- Redeployment of support staff from other local authority functions for a fixed term; and
- Redeployment of staff from the police for a fixed term.

2.52 If the national situation is so adverse that there is no potential for mutual aid arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.53 Key measures for local planners to focus on are listed below:

Measures for Augmenting Local Capacity	Departmental Policy Lead	Local Lead	Planning Notes
Deploy judicial resources efficiently – for example, it may be necessary to adjourn some inquests in order to prioritise decision-making on report of death.	Chief Coroner's Officer	Coroner	Should be included and detailed in LRF plans.
Cross-appointment of Senior Coroners to other jurisdictions.	MoJ Chief Coroner's Office	Coroner	LRFs should consider this as a potential option in their excess deaths plans.
Consider how evidence can best be heard in inquest hearings which go ahead during the	Chief Coroner's Office	Coroner	LRFs plans should cover the need for evidence to be heard, and the potential

pandemic, including whether there are better options than taking oral evidence.			use of alternative means of taking oral evidence.
Appoint and deploy additional administrative staff to support the Coroner.	MHCLG	Coroner Local Authority Police	Should be included and detailed in LRF plans, with options such as creation of a pre-identified pool of suitable candidates.
Appointment of additional Coroners, complying with necessary experience requirements.	MoJ Chief Coroner's Office Local authorities	Coroner	LRFs should include this option in their excess deaths plans.
Amend the requirement to refer deaths to the Coroner if the registered medical practitioner (who must have attended the deceased during their final illness) who certified the cause of death had seen neither the body after death nor the patient within 14 days of their death to 28 days.	MoJ DHSC Home Office	Coroner NHS	LRFs should consider this as a potential measure to be reflected in their excess deaths plans. Local planners will be notified if and when this measure is to be introduced.
A monitoring system could be put in place on a regional basis which could distribute cases evenly amongst available Coroners.	MHCLG DHSC	Coroner NHS	Should be included and detailed in LRF plans. Although no Central Government action is required, it would be expected that such a move would follow an advice note to ensure national coherence.

Death Registration

Background

2.54 All deaths within England have to be registered with a Registrar. Registrars are employees of the respective local authorities. Funerals cannot take place until certificates for burial or cremation have been issued either by the Registrar or by the Coroner. The Registrar needs to register the death before issuing a death certificate. Registration normally needs to occur within five days of the death in England, Wales and Northern Ireland and within eight days of the death in Scotland, unless the death is being investigated by a Coroner or Procurator Fiscal. The registration must take place in the same district as the death took place.

Legislation, Regulation and Guidance to Consider

2.55 **Registration of Births and Deaths Regulations 1987** allows still-births to be registered more than three months after a child has been still-born. This allows for this process to be undertaken after a pandemic has potentially ended, though careful consideration will be needed as to whether and how this is applied. Registration of births and deaths (and of places of worship) are reserved to the UK Government under Section L14 of Schedule 7A of the Government of Wales Act 2006.

2.56 **Pandemic Influenza: Guidance on the management of death certification**

and cremation certification states that where the proposed method of disposal is by burial, authorisation is effected by a Coroner's disposal order or the Registrar's disposal certificate (normally following registration of the death). No changes to these requirements are proposed for the purposes of facilitating burial in the context of a pandemic.

Roles & Responsibilities

2.57 Registration legislation requires a 'qualified informant', usually a relative but alternatively someone present at the death or who is arranging the funeral, to provide the relevant information to the Registrar.

2.58 If the Registrar is satisfied with the information provided, they may then issue the [green] Certificate for Burial or Cremation.

2.59 The Office for National Statistics (ONS) is responsible for reporting on the number of registered deaths. The Registrar is tasked with updating the ONS.

2.60 Registrars, and where relevant Coroners, direct all relatives of the deceased to the Department for Work and Pensions (DWP) '*What to Do After a Death*'[3].

Measures for Augmenting Local Capacity

2.61 The ability of Registrars in each local authority to manage the potential demand for death registrations is likely to vary by area. Local authorities might consider including the following options in their business continuity plans:

- Employment of extra staff to act as Deputy Registrars, and the provision of necessary training;
- Contact between registration districts to explore potential for interchange of staff to cover absenteeism;
- Extension of opening hours, incorporation of shift working, and moving to a seven day working week;
- Rationalising work processes; prioritising death services and deferring activity on births, marriages and civil partnerships, where possible;
- Delaying the issue of birth, marriage and death certificates unless they are required urgently (e.g. for investigation purposes); and
- Publicity of arrangements for death registration through local press, websites, and notices.

2.62 The DWP and its Executive Agencies including Jobcentre Plus should have resilient business continuity arrangements to ensure the administration of key services, that support payments, can be maintained during a pandemic. Using existing legislation, a number of changes can be made to the way key services are delivered during a pandemic, to take account of priorities at the time,

[3] What to do when someone dies: step by step

particularly funeral payments.

2.63 If the national situation is so adverse that there is no potential for mutual aid arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.64 Key measures for local planners to focus on are listed below:

Measures for Augmenting Local Capacity	Departmental Policy Lead	Local Lead	Planning Notes
Extension of working hours by Registrars.	HO (GRO)	Local Authority	Should be included and detailed in LRF plans.
Prioritising death services and deferring activity on births, marriages and civil partnerships.	HO (GRO)	Local Authority	Should be included and detailed in LRF plans.
Remote registration of death using phone, fax and/or email.	HO (GRO)	Local Authority	LRFs should consider this as a potential measure which may be introduced. Local planners will be notified if and when this measure is to be introduced.
Use of funeral director to act as qualified informants on behalf of family.	HO (GRO)	Local Authority	LRFs should consider this as a potential measure to be reflected in their excess deaths plans. Local planners will be notified if and when this measure is to be introduced.
Primary legislation to remove requirement for Registrar to see original MCCD before issuing death certificate.	HO (GRO)	Local Authority	LRFs may wish to consider this as an option of the last resort, but would not be expected to have detailed plans in place to implement it. Local planners will be notified if and when this measure is to be introduced.
Secure additional Registrars through mutual aid.	HO (GRO)	Local Authority	Should be included as potential option in LRF plans, but may not be available depending on the spread of the pandemic.

Body Storage

Background

2.65 Existing facilities for storing bodies are found within hospitals, public and private mortuaries and Funeral Director's premises as well as a very limited quantity of temporary body storage facilities maintained as part of the legacy from the former National Emergency Mortuary Arrangements (NEMA). NHS mortuaries are not always for patients who die in the direct care of the NHS e.g. in hospital or in an ambulance, but in many areas make up the only public mortuary capacity available and in this instance are part-funded by local authorities.

2.66 Body storage is required for initial storage of the deceased pending death certification and registration; awaiting investigation by a Coroner; and/or awaiting burial or cremation.

2.67 It is important to distinguish between body storage and temporary mortuaries. For the purposes of this section, body storage is for the temporary storage of the deceased resulting from the overwhelming of existing storage capacity and does not include the provision of temporary mortuary capacity e.g. facilities to undertake post-mortems.

2.68 While the other measures detailed within this framework will provide an increased capacity in each part of the death management process it is likely that they will still become overwhelmed during a pandemic. Effective temporary body storage capacity provides a buffer to allow the other parts of the process to continue to function before any further exceptional measures being required.

Legislation, Regulation and Guidance to Consider

2.69 **DHSC Health Building Note 20 – Facilities for Mortuary and Post-Mortem Room Services (England and Wales); Mortuary and post mortem facilities: Design and Briefing Guidance (Scottish Health Planning Note 16-01); Health and Safety at Work Act 1974, Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health (COSHH) Regulations 2002, HSE Guidance on Managing Infection Risks When Handling the Deceased, Human Tissue Act 2004 and Care and Respect in Death Good Practice Guidance for NHS Mortuary Staff** have been reviewed to produce the information below for the construction, equipping, staffing and running of a temporary body storage facility.

Accommodation & Equipment

2.70 The recommended minimum standards when identifying an appropriate building for temporary body storage are:

- Single level (ground floor) access for loading / unloading;
- Secured premises[4];
- Access for vehicles 24hrs a day;
- Entrance not overlooked by public view (shielded using tenting if required, so vehicles can unload under cover);
- Electricity and water supply;
- Appropriate height for storage racking for bodies three high (see separate section below); and
- Office and welfare facilities.

2.71 The storage facility described does not have the ability to undertake any mortuary proceedings. Additional storage facilities for existing hospital and public

[4] If the space being used is considered to have inadequate security i.e. a demountable structure, collection of ISO containers and Portacabins; a secure, regularly patrolled perimeter fence will need to be constructed.

mortuaries should be detailed within these premises existing business continuity plans.

2.72 Floors should be sealed, impervious concrete or covered in non-slip waterproof rubber flooring, allowing for easy cleaning of contaminants and to prevent any risk of contamination spreading. Consideration must to be given to the lawful disposal of cleaning and disinfectant (C&D) chemicals/wash-waters generated either during storage or when the bodies have been removed and the building is cleaned. Vast quantities of C&D wash-water effluent are likely to be produced and if these are disposed in to the environment, environmental risk assessments and environmental permits are required prior to discharge. Early engagement with the Environment Agency is recommended.

2.73 It is recommended the following equipment should be provided:

- 'A' frame ladders (height greater than top shelf of racking);
- Hydraulic or electric lift transport trolley (maximum lift exceeds height of top shelf of racking);
- Single-man hoist;
- Body racking (see section below for details);
- Chiller unit;
- IT and printers;
- Phone;
- Staff washing and toilet facilities;
- Boot washing facility;
- Staff welfare facility;
- Clinical waste bins for cleaning materials;
- Appropriate PPE (see section on Body Transport above);
- Storage facility for clinical waste prior to collection;
- Cleaning materials;
- Secure valuables/property store;
- Pest control measures;
- Back up chiller unit; and
- Standby electricity generator.

Viewing

2.74 A family viewing area within the facility would ideally be provided, especially if the deceased are expected to be stored for some time, however there is a recognition that these visits can be disruptive and time consuming to the mortuary's core activities.

2.75 Options for specialist staff to facilitate viewing where possible should be considered. This should take place in a separate room within the building or within a demountable structure adjacent to the storage facility.

2.76 The following principles should be followed when arranging viewings for the

deceased:

- Ensure the room to be used is hygienic, sensitive to the bereaved's needs and fit for purpose;
- Supply hand washing facilities for those attending (for religious and hygiene purposes); and
- Ensure a trained professional is carrying out the viewing arrangements.

2.77 When a viewing request is received, the deceased's next of kin should be notified of the details and permission to fulfil the request discussed. The next of kin may wish to be present when any visit takes place or may put restrictions on who can visit and whether they can be left alone with the body.

Faith and Particular Needs

2.78 Where practical, separate areas within the storage facility should be designated for certain faith groups. Bodies from the same faith should be kept together, where possible.

- Hindu – racking to enable head to face north and feet south;
- Jewish – racking to enable feet towards the doorway; and
- Muslim – racking to enable face to be positioned towards Mecca.

2.79 It is also recommended that the bodies of babies, small children and the bariatric are stored in areas with appropriate racking.

Body Racking

2.80 Bodies should be contained within appropriate vessels (see section on *Body Transportation* above), and if limitations on space requires, stacked on body racking.

2.81 Any metal component shelving will serve the purpose for emergency body racking providing:

- It is heavy duty (legs capable of holding 75 stone/500 kilos plus the weight of the metal, shelves 25 stone); and
- If scaffolding is used, it is disinfected before and after use.

2.82 If wood is used it is recommended that it is covered/sealed with heavy duty polythene in order to allow ease of disinfection and destroyed after use (incinerated as clinical waste). Any bodies heavier than the maximum load of a shelf should be placed on plastic sheeting on the floor within a body bag.

2.83 The approximate dimensions for shelving three shelves high) are:

- Length – 2430mm (8ft);

- Width – 910mm (3ft);
- Height gap between shelves – 750mm (2.5ft) (check maximum lift exceeds height of top shelf of racking);
- Gap between floor and 1st shelf – 300mm; and
- Distance between racks to provide a safe working aisle for movement of bodies on and off the shelving –1800mm (6ft).

Personal Effects/Valuables

2.84 Jewellery and other personal effects of the deceased may have a special significance to the bereaved. It is therefore vital that all property is handled with care and respect.

2.85 All items remaining with the deceased should be bagged and labelled accurately to ensure the safe return to the next of kin. Assumptions should not be made about what should be destroyed or returned although in some cases it may be wise to separate items which are soiled. All personal effects that arrive at the facility should be placed in a security sealed bag or bags with a full detailed listing. Bags should be stored securely, and should only be removed for viewing on request by the next of kin or when the deceased leaves the facility. These bags should be labelled accordingly to retain a link to the deceased.

Body Identification and Labelling

2.86 Correct body labelling is vital in the process of body storage. Bodies should be able to be easily identified using a pre-identified labelling system and segregated within the facility based on their progression through the death management process e.g. awaiting burial, under investigation by the Coroner etc. The labelling system must include a minimum of three identifiers (including one unique identifier) of the deceased. There should be systems to flag same or similar names of the deceased.

2.87 It is imperative for the operation that there is a bay numbering system in place so that the location within the facility of each body is known. Failure to do this will result in delays in releasing the deceased and introduce a significant risk of error. This system will allow for easy retrieval and identification from the IT system and allows the deceased to remain as anonymous as possible.

Operating Procedures

2.88 It is the responsibility of staff to care for and keep secure the bodies of people who are brought to the facility for storage. Procedures are needed which should ensure all bodies are tracked from collection to arrival and then release. Policies on operation and documentation procedures must be put in place and monitored regularly.

2.89 Policy and practice in the facility must demonstrate respect towards those who have died and the bereaved. Bodies and any personal belongings must be able

to be located at any time, and bodies must be kept in the best possible condition, protected from interference, accidental damage and avoidable deterioration.

2.90 Additionally, methodical, accurate and monitored systems are vital in order to protect staff responsible for the safe-keeping of the bodies, personal belongings of the deceased as well as providing complete and accurate records for audit and possible future reference required during enquires. The following systems should be adopted:

- A single system of identification and tracking of bodies;
- Staff register for in / out of storage facility;
- Log-book for regular building temperature checks;
- Accident at work log-book;
- Clearly defined clean and dirty areas:
    - Clean: offices, storage for staff personal belongings, staff rest room and equipment store room;
    - Boundary area: Staff changing and showering facilities;
    - Dirty: receiving, storage of deceased, clinical waste facilities; and
- Regular, monitored deep cleaning of the facility (at least once a day) with spillages dealt with immediately.

Temperature Control

2.91 Keeping the remains cold limits the rate of decomposition by slowing the growth of bacteria which contributes to the decomposition process[5]. Bodies should be kept at a temperature of 4^{o}C or less for a maximum period of 30 days. Beyond this period, or earlier depending on the condition of the body, bodies should be frozen.

2.92 Optimum temperatures will be obtained and maintained in large spaces easier if they are divided by floor to ceiling partitions. These can be as simple as sheets of thick plastic membrane attached to heavy duty rails or sides of the racking. There should be appropriate temperature monitoring and alarm systems.

Ventilation

2.93 Windows or other openings should provide sufficient ventilation[6] in some or all parts of the storage facility however, measures will need to be taken to control the entry of pests such as insects, birds and rodents. Where this cannot be ensured or inadequate sources do not exist, mechanical ventilation systems should be provided.

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[5] Certain drugs administered before death may influence the rate of decomposition. If this is considered to be a risk, advice should be taken from professionals who are aware of the deceased's medical history.

[6] If embalming is being carried out on site, additional local exhaust ventilation is required to control levels of formaldehyde.

Cleaning

2.94 Cleaning and disinfection are particularly important where there is a need to control the risk of exposure to infectious microorganisms, including work surfaces, tables, benches and floors, equipment and PPE. Relevant procedures include:

- Wet brushing with disinfectant[7] for cleaning large areas;
- Equipment such as boots should be washed, dried and stored in the clean area whilst not in use; and
- Suits and gloves should be disposed of as clinical waste. Arrangements will need to be in place for collection by a licensed contractor.

Security

2.95 High standards of security are essential to protect the bodies and personal effects of those who have died. Security involves both appropriate facilities and efficient systems and procedures. The environment will need to be properly secure and the highest possible standards of care delivered to the deceased and, where relevant, their bereaved families. Security specialists should be consulted when planning for a body storage facility. As a minimum requirement the facility should be alarmed and patrolled on a regular basis but any security assessment should include consideration of an integrated security solution, using a combination of physical controls or systems such as closed circuit television, locked and alarmed emergency exits, access controls, intercoms and remote door releases.

Licensing

2.96 **The Human Tissue Act 2004** states the following activities can only take place under the authority of a licence from the Human Tissue Authority (HTA):

- The making of a post-mortem examination;
- The storage of the body of a deceased person or relevant material which has come from the human body for use for a scheduled purpose; or
- The removal from the body of a deceased person (otherwise than in the course of anatomical examination or post-mortem examination) or relevant material of which the body consists or which it contains, for use for a scheduled purpose.

2.97 Scheduled purposes within the Act are stated below:

- Anatomical examination;
- Determining the cause of death;
- Establishing after a person's death the efficacy of any drug or other treatment administered to deceased;

[7] Ensure any disinfectant used for cleaning is compatible with other chemicals that may be in use, for example formaldehyde.

- Obtaining scientific or medical information about a living or deceased person which may be relevant to any other person (including a future person);
- Public display;
- Research in connection with disorders, or the functioning, of the human body;
- Transplantation;
- Clinical audit;
- Education or training relating to human health;
- Performance assessment;
- Public health monitoring; or
- Quality assurance.

2.98 Premises where licensed activities take place need to be licensed by the HTA.

2.99 Premises on which post-mortem examinations are conducted must be licensed by the HTA for the activity “making of a post-mortem examination”.

2.100 Body storage facilities where bodies are stored temporarily (and for no longer than a week) before being moved to HTA-licensed premises for post-mortem examination do not need to be licensed for storage activity. This is because the licensing exemption under section 16 of the HTA will apply. This means in cases where there is doubt about the cause of death and post-mortems are authorised, the bodies may be stored for up to seven days in the emergency temporary storage facility before being moved to the licensed premises where the post-mortem examination will take place.

2.101 However, in the case of a pandemic, there will be a greater number of post-mortems required by the Coroner. This may require bodies to be stored for longer than seven days in temporary facilities prior to a post-mortem; meaning these facilities will be subject to licensing.

2.102 Body storage facilities where bodies are stored only prior to being buried or cremated do not need to be licensed by the HTA. This is because the bodies are not being stored for use for a scheduled purpose under the Human Tissue Act 2004.

2.103 The HTA is the agency responsible for licensing and has developed a system for the provision of a license in an emergency. The HTA works within the statutory framework imposed by the Human Tissue Act 2004 and the following legal requirements need to be met before they can issue a license:

- Received a license application form;
- Be satisfied that the proposed Designated Individual (DI) is a suitable person;
- Be satisfied that the proposed License Holder (LH) is a suitable person / entity;
- Be satisfied that the premises are suitable; and

- The license and any conditions must be acknowledged in writing by the DI and LH.

2.104 Local authorities and NHS Trusts in collaboration with the Coroner should complete a license application form, providing detailed information to demonstrate that the body storage facilities/mortuaries comply with the HTA Standards. The application need not be submitted to the HTA unless a license is required, but should be subject to regular review to ensure that the evidence prepared and gathered against the HTA Standards is up-to-date.

2.105 **HTA Guidance on HTA Licensing of Emergency Mortuaries** provides a detailed breakdown of how to fill in the license forms and what the HTA Standards specify is acceptable for a temporary body storage facility/mortuary. These standards have been consulted when detailing the requirements previously in this section.

2.106 At a local level the role of Designated Individual (the person under whose supervision the licensed activity is undertaken) should be predetermined prior to a pandemic. The HTA is not prescriptive about who this person is; however, it should be someone who has an understanding of the Human Tissue Act 2004 and the licensing requirements and who can supervise the operational activities which take place in the facility being licensed.

2.107 In the event that a licence is required, the HTA should be notified as soon as possible. The HTA will assess the licence application – this may include HTA representatives attending the facility. The HTA will review the information provided in the license application and provide direct advice and guidance on the requirements of the Human Tissue Act 2004 and compliance with the HTA Standards. The intention is to issue the relevant licenses at the inspection prior to the facility becoming operational and without delaying activity.

2.108 Facilities can be erected and body recovery and storage initiated before a licence is granted. However, the relevant licences must be in place before licensable activities can commence.

Planning Permission

2.109 Should the availability of pre-existing storage facilities for body storage be lacking and a facility is required quickly, **Permitted Development Rights (PDR)** set out in the **General Permitted Development Order 2015** allow the Crown[8] to use its land to prevent or mitigate an emergency, which includes preventing loss of human life and human illness or injury. The land has to be returned to its previous use within six months, or during that time planning permission would have to be secured for the specific purpose. There are no specific planning requirements for

[8]Crown Land is land owned by the Monarch which includes most of the land and buildings occupied by Central Government. Not all Ministry of Defence property is Crown Land. Local Authority land is not Crown Land.

facilities intending to store bodies. Bodies are denoted as goods, not waste and Funeral Directors premises are classed as retail. Consideration should always be given to the location from an environmental perspective too i.e. avoiding, where possible, storage locations inside Groundwater Source Protection Zones (SPZs) or other environmentally vulnerable areas.

2.110 There is also a PDR which allows for the provision of land or buildings, moveable structures, works, plant etc. required temporarily in connection with and for the duration of operations being or to be carried out on, in, under or over that land. The only condition is that the structures are removed as soon as it is no longer needed for those operations. PDR cannot be used if the development requires an Environmental Impact Assessment.

Roles & Responsibilities

2.111 NHS Trusts and local authorities should already have contingency plans for increasing body storage capacity for current risks such as seasonal flu. Temporary facilities must meet minimum standards of permanent mortuaries to respect the dignity of the deceased.

2.112 NHS Trusts and local authorities in collaboration with the Coroner, the Environment Agency and potentially commercial suppliers, have the expertise, mechanisms and resources to plan for and implement a temporary body storage facility. This is a crucial aspect of any excess deaths response and should be overseen by a Body Storage Coordination Cell, as a sub-group of an established Strategic Coordination Group.

Measures for Augmenting Local Capacity

2.113 An outline specification for temporary facilities is included above. This is offered as an indicative guide for NHS Trusts and local authorities to consider. Such facilities should replicate existing storage arrangements as far as possible and determine local strategies for providing additional storage capacity.

2.114 If the national situation is so adverse that there is no potential for mutual aid arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.115 Key measures for local planners to focus on are listed below:

Measures for Augmenting Local Capacity	Departmental Policy Lead	Local Lead	Planning Notes
Establish a mechanism to coordinate the procurement, staffing and storage of all bodies.		Local authority NHS Coroner	LRFs should have plans in place to set up a coordination group for all matters relating to body storage, possibly as part of a wider excess deaths group within the SCG.

Identify potential facilities/premises which may be suitable for body storage locally.	MHCLG HTA	Local authority NHS Coroner	In addition to existing plans for augmenting local body storage capacity, LRFs may want to establish the availability locally of suitable facilities/premises, which might be acquired should it become necessary. Local plans should cover how auxiliary local storage and larger storage facilities, potentially some distance away, could be integrated with existing provision.
Use of military assets and buildings to store the deceased.	MoD	JRLO	LRFs may want to consider the potential use of military estate or personnel to assist with body storage, but should not rely on this option being available. Any requests would have to follow Military Aid to the Civil Authorities (MACA) protocol.
Use of capacity in neighbouring regions to deal with localised excess deaths.		Local authority NHS Coroner	LRFs should be aware of body storage capacity plans in neighbouring LRFs and reflect these in their own plans. LRFs should not rely on mutual aid as all areas may be overwhelmed in a pandemic.

Body Disposal

Funeral Directors

Background

2.116 Funeral directors are non-regulated commercial entities, based entirely on the customs, habits and preferences of individuals and of wider faith and community groups. Funeral directors are not emergency responders under Part 1 of the CCA 2004 and therefore have no legal duty to contribute to local contingency planning.

2.117 Local Funeral Directors will have extensive experience of the entire death management process and may also be able to provide key capabilities such as body transport and storage.

Legislation, Regulation and Guidance to Consider

2.118 **Civil Contingencies Act 2004.** The CCA 2004 requires local authorities to provide advice and assistance on business continuity to organisations in their area. For excess deaths, this is particularly important for those business areas which perform a function of the death management process, including private cemeteries and crematoriums and the Funeral Directors sector.

Roles & Responsibilities

2.119 Funeral directors provide an expertise in the handling and transportation of the dead. While they have no obligation to engage with local planners, their expertise, capability and capacity for storing the deceased will be invaluable when planning and responding to an excess deaths scenario locally.

2.120 Achieving efficiencies in the processes funeral directors undertake while retaining the dignity of the deceased and respect for the bereaved will be one of the most

important elements in ensuring that the excess deaths process works smoothly.

2.121 It is crucial that local Funeral Directors and faith and community representatives are engaged in local planning at the earliest possible stage.

2.122 The aim is to maintain Funeral Directors services as near to normal as possible for as long as possible. However, it may become necessary for Funeral Directors to be asked to offer more limited choices to family members in order to enhance their capacity. Restricting choice is unlikely to mean removing the option of having a funeral. Local planners should ensure that those directly involved in conducting funerals are aware of the options for limiting or restricting them. It is important that any public communications clearly explain why such limitations have become necessary.

2.123 Funeral Directors and Registrars should work together to ensure deaths are registered in a timely way. Both will also need to be encouraged to consider ways in which they might be able to increase their capacity to hold the deceased prior to funerals, including for longer periods of time.

Repatriation of Deceased Foreign Nationals Resident in England

2.124 Repatriation of deceased foreign nationals (from the UK to overseas) is usually organised by specialist Funeral Directors. Provided the death was judged to be from natural causes, the following prerequisites must be met to ensure that the remains can be repatriated:

- A Death Certificate;
- A Funeral Director's certificate, confirming that the body is sealed within a zinc-lined coffin;
- An embalming certificate (should it be required), for the airline transporting the body;
- An '*Out of England and Wales*' certificate issued by the Coroner; and
- For certain countries, a Freedom from Infection Certificate is required. This would normally be issued by the deceased's attending doctor.

2.125 As noted above, it is likely that a high volume of deaths will force local body disposal. No specific trigger point has been specified for a move to this stance, but communication will be required to manage expectations and a decision taken locally between responders and Funeral Directors.

Measures for Augmenting Local Capacity

2.126 Funeral Directors, working in partnership with faith and community representatives, cemeteries and crematoria managers, should consider the following business continuity measures, which should be included in LRF plans as baseline measures:

- Introduction of a variety of measures relating to normal work patterns

including:
    - Shift working;
    - Working hours increased; and
    - Businesses moving to seven days a week operation (should they not currently offer this service).
- Staff roles reevaluated and essential services only are maintained e.g.:
    - The deceased are taken to the place of worship or equivalent;
    - No car service is offered; and
    - Bereaved persons attending funerals are met at the chapel.
- Where several businesses are owned or networked, agreements to pool resources (e.g. reception staff, telephone operators, private ambulances) should be arranged;
- Agreements could be negotiated whereby funeral staff will support burial and cremation staff by taking on agreed non-technical duties at the chapel, crematorium, and cemetery, with a view to assisting cemeteries and crematoria to deploy their own staff to other essential duties;
- Employment of extra staff to act under the supervision of existing staff;
- A limited choice of types and sizes of coffins is offered, to ensure manufacturers can increase production; and
- Those arranging and conducting funerals should prepare for shorter services at the chapel, or for memorial services to be held at other venues (e.g. the home or place of worship).

2.127 Faith and community representatives will also want to consider the impacts of a pandemic on their organisations. They will want to consider:

- What they might do to increase their capacity to provide funeral services;
- How these will fit with the changes being implemented by the other organisations in the process;
- Whether they can sustain services taking place at the cemetery or crematorium chapel, chosen place of worship, home, or other setting; and
- Whether they can sustain provision to support the bereaved, where required, in light of their other community responsibilities (e.g. supporting local social care services) and, if so, what alternative sources of support might be found.

2.128 If the national situation is so adverse that there is no potential for mutual aid arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.129 Key measures for local planners to focus on are listed below:

Measures for Augmenting Local Capacity	Departmental Policy Lead	Local Lead	Planning Notes
Shortening or deferral of religious and civil services.	MHCLG	Local authorities	Should be scoped as a potential option in LRF plans.

Shortening or deferral of ceremonies.	MHCLG	Local authorities	Should be scoped as a potential option in LRF plans.

Burials and Cremations

Background

2.130 Local authorities provide the majority of cemetery and crematoria capacity across England, with the Church of England, other faith groups and the private sector, including churchyards, offering additional capacity in most areas. The percentage of the dead being buried has steadily been declining nationally, however local trends in body disposal practices should be investigated when planning locally. This will help to determine where capacity will be required. Nationally, personal choice of body disposal results in around 20-25% of people being buried and 75-80% cremated, but this varies locally.

Legislation, Regulation and Guidance to Consider

Crematoriums

2.131 Air pollution is covered by the **Environmental Permitting Regulations (EPR) 2016**. EPR 2016 implementing the air protection objectives of the:

- **Pollution Prevention and Control Act 1999**; and
- **Statutory Guidance for Crematoria (Process Guidance Note 5/2 (12))**

2.132 These limit the units of milligrams of emissions to a cubic meter of air. If a crematorium was required to work longer i.e. 24/7 working, it is unlikely any relaxation to the permissions would be required unless for any reason, bodies were required to be cremated at the same time reaching or exceeding the milligrams of emissions.

2.133 Most crematoria will have installed mercury filters. After filtration, crematoria report the emissions either experienced per cubic meter or per cremation depending on the individual local authority requirements.

2.134 If there is no filter, there are mass emission limits for unabated crematoriums. For those crematoria that choose not to install an abatement plant, they have to purchase ‘credits’ from the **Crematoria Abatement of Mercury Emissions Organisation (CAMEO) Burden Sharing Scheme**. The requirement to purchase more credits should be considered during an excess deaths scenario.

2.135 **Cremation (England and Wales) Regulations 2017** states that Cremation legislative amendments will be made to introduce a streamlined version of Cremation Form 4 and to suspend the requirement for Cremation Form 5 during a pandemic.

2.136 **Pandemic Influenza: Guidance on the management of death certification**

and cremation certification states that as well as contributing to the process of death certification, additional medical practitioners may also be able to assist by being appointed to medical referee in local crematoria, by the Ministry of Justice, in order to relieve pressure on existing medical referees and promote business continuity in the event of sickness absence of medical referees. To be appointed as a medical referee, a medical practitioner must be a registered medical practitioner for at least five years' standing.

2.137 For cremation, a separate application is made to the crematorium on the statutory Application for Cremation (known as Cremation Form 1), usually by the deceased's executor or next of kin. The applicant has to provide details including their relationship to the deceased; the place, time and date of death; whether there may be any reason to suspect violence, poison or neglect; whether there is any reason to think an examination of the remains is desirable; and details of the patient's general medical practitioner. This form is passed to the relevant crematorium. There is also a requirement for a Medical Certificate (Cremation Form 4) which is completed by a registered medical practitioner. This medical practitioner can be the same one who completed the MCCD.

2.138 The Confirmatory Medical Certificate (Cremation Form 5) must be completed by a different medical practitioner, who must not be a relative of the deceased or a relative or partner of the registered medical practitioner who completed the Cremation Form 4 and who has been registered with the General Medical Council for at least five years.

2.139 The Authorisation of Cremation of Deceased Person by Medical Referee (Cremation Form 10) is completed by the medical referee, authorising the crematorium to cremate the body. The medical referee may make any appropriate enquires of the other signatories, and may refuse cremation until a post-mortem is carried out.

2.140 Local areas should undertake a detailed review of their crematoria and cemetery capacity and clarify the demand and preference for these services in order to determine how to prioritise resources and personnel (skilled and unskilled) during a pandemic.

Burial

2.141 Protecting groundwater from pollution is covered by the **Environmental Permitting Regulations (EPR) 2016**. EPR 2016 implements the groundwater protection objectives of the:

- **Water Framework Directive (WFD) - establishing a framework for community action in the field of water policy (2000/60/EC)**; and
- **Groundwater Directive (GWD) - on the protection of groundwater against pollution and deterioration (2006/118/EC)**.

2.142 They specifically require that the EA (as the regulator) must, in exercising their relevant functions, take all necessary measures to:

- Prevent the input of any hazardous substance to groundwater, and
- Limit the input of non-hazardous pollutants to groundwater so as to ensure that such inputs do not cause pollution of groundwater.

2.143 Human burial may give rise to inputs of pollutants, if they are not managed in an environmentally acceptable way. It is also important to note that it makes no difference if the pollutants are formally classified as a waste or not. So, whilst human remains are not considered a waste, pollutants arising from burials fall within the controlling remit of EPR 2016. Any permit for community burials would require the burials to be undertaken in an environmentally acceptable manner and would be enforced under the groundwater activity (Schedule 22) aspects of EPR 2016 referenced above.

2.144 Environmental impact of normal cemeteries is assessed based on an annual average burial rate. While a site might be suitable for 10 burials a year it might not be suitable for a higher burial rate as in an excess deaths scenario. Therefore, all sites should be environmentally screened in advance of a pandemic. Burial plots should be at least 250m away from a borehole, spring or well used for the supply of water for human consumption or used in food production and/or bottling of mineral water. In addition a burial site must be outside a groundwater Source Protection Zone 1 (SPZ1). However, considering the high number of burials over a short space of time this protective radius is likely to be extended. The EA's **Groundwater Protection Policy** designates different Source Protection Zones. The **Cemeteries and Burials: Prevent Groundwater Pollution Guidance 2017** specifies in addition to the above that the minimum requirements are that:

- Burial plots should be at least 50m away from all other boreholes, springs or wells;
- Burial plots should be at least 50m away from a river, canal, lake, wetland or the coast;
- Burial plots should be at least 10m away from field drains (this also includes old agricultural drainage systems no longer in use as they can act as preferential pathways);
- If bedrock is encountered in the trial pit, that area of the site should not be used for burials;
- The area of the site is not suitable for burial if there is standing water at the bottom of the burial pit when first dug or the area is susceptible to groundwater flooding;
- There should be no sand and gravel at the bottom of the burial pit; and
- There should be at least 1m of subsoil below the base of the lowest coffin.

2.145 During a pandemic the demand for home burials could potentially rise. The **Registration of Burials Act 1864** states to bury individual human remains at home, you must:

- Fill in a Burial Authorisation Form before the burial takes place via a local authority;
- Record the burial in a land burial register;
- Follow the minimum groundwater protection requirements; and
- A detailed plan showing where the burial took place should be kept with the deeds of the property or land.

2.146 Local authorities have a power to acquire land for burial grounds under the **Local Government Act 1972**. As there is not a PDR for the development of cemeteries an application for planning permission would be required for this use.

2.147 The **Permitted Development Rights** allow Crown Land[9] to be used to prevent or mitigate an emergency, which includes preventing loss of human life and human illness or injury. The land has to be returned to its previous use within six months, or during that time permanent planning permission could be secured for use as a cemetery.

2.148 **Permitted Development Rights** do not allow development that falls under the Habitats or Environmental Impact Assessment (EIA) Directives. Cemetery and crematorium developments are not named as development types in the **Town and Country Planning (Environmental Impact Assessment) Regulations 2017**. However, activities associated with these developments are listed in these Regulations and so an EIA may be required. The Regulations list applicable thresholds and criteria which apply to Schedule 1 and Schedule 2 developments.

2.149 The Ministry of Housing, Communities and Local Government (MHCLG) Secretary of State can provide an exemption from the requirements of EIA Regulations in the following circumstances; the development has national defence or the response to civil emergency as its sole purpose, and delay would have an adverse effect on that purpose, or under exceptional circumstances, despite an EIA not being carried out the objectives of the Directive will be met. In the latter case the Secretary of State must have considered whether an alternative form of assessment would be appropriate. Therefore, it may still be that an EIA is required in order to determine that the effect on the environment has been 'adequately assessed' in a proportionate way.

2.150 Cemeteries are specifically listed as an exception to inappropriate development in designated Green Belt areas as long as the facilities preserve the openness of the Green Belt and do not conflict with the purposes of including land within it.

Roles & Responsibilities

2.151 Private and public sector cemetery and crematoria operators should be consulted

[9] Crown Land is land owned by the Monarch which includes most of the land and buildings occupied by Central Government. Not all Ministry of Defence property is Crown Land. Local Authority land is not Crown Land.

when undertaking excess deaths planning, although there is no legal obligation for them to engage. Some cemeteries will have sufficient burial capacity for a number of years and potentially be able to find additional space for burials. Many, however, will have a shortage of grave space, particularly in inner-city areas. Forward planning and gaining an understanding of local burial capacity, for use during and after the pandemic, is advised.

2.152 Local planners, in developing plans for the cremation of bodies in a pandemic, should understand their maximum local capability for cremation and plan accordingly. Not all local authorities will have access to a public crematorium, therefore early engagement with the private sector is crucial.

2.153 The Environment Agency (EA) should be factored into discussions at the local level so that risk assessments of existing or new burial grounds can be undertaken, and advice be provided, before decisions are made. The EA in England is the regulator and legally required to ensure groundwater and surface water quality is protected, and activities (such as burials), that may put groundwater or surface water at risk, are appropriately regulated.

Measures for Augmenting Local Capacity

2.154 Some key areas where business continuity of burial and crematoria services can be enhanced are shown below:

- Extending opening hours and working days, to cope with increased burials and cremations, and absenteeism;
- Redeploying staff from other local authority functions;
- Arranging maintenance and inspection of equipment ahead of periods of peak usage, with back-up equipment and replacement parts stockpiled;
- Collaborative working with funeral director staff – allowing staff normally required for committals to be redeployed elsewhere; and
- Encouraging funeral services to be held in local places of worship; other venues and shorter time slots for committals.

2.155 If the national situation is so adverse that there is no potential for mutual aid arrangements, Central Government may consider a number of measures for augmenting local capacity.

2.156 Key measures for local planners to focus on are listed below:

Measures for Augmenting Local Capacity	Departmental Policy Lead	Local Lead	Planning Notes
Restrict choice to the public regarding burial and cremation.		Local authorities	LRFs should include this as a potential option which may need to be implemented.

Use of military personnel and equipment to support the burial process.	MoD	JRLO	Any requests have to comply fully with the conditions attached to MACA, and may not be approved.
Acceptance of burials on private land by those wishing to do so.		Local authorities	LRFs should be wary of promoting this option to avoid circumstances arising whereby such burials take place unnecessarily.
Accelerated acquisition of land for use as burial grounds.	MHCLG	Local authorities	LRFs may want to consider, in event that the powers are granted, how suitable land would be acquired and developed within a very compressed timeframe.
Potential powers for local authorities to require body disposal, or particular forms of disposal, to be undertaken or prevent particular forms of disposal.	MHCLG	Local authorities	LRFs may wish to consider this as an option of last resort, but would not be expected to have detailed plans in place to implement it.
Adapting to amendments to Cremation Regulations 2008 which streamline relevant forms.	MoJ	Local authorities	LRFs may wish to consider how this would be applied to existing death management processes, should it be introduced.
Secure additional staff to assist with burials through mutual aid.		Local authorities	Should be included and detailed in LRF plans. However, LRFs should not rely on mutual aid as all areas may be overwhelmed in a pandemic.
Secure additional cremation staff through mutual aid.		Local authorities	Should be included and detailed in LRF plans. However, LRFs should not rely on mutual aid as all areas may be overwhelmed in a pandemic.
Extend working hours of staff involved in burials.		Local authorities	Should be included and detailed in LRF plans.
Appointment of doctors or retired doctors to act as medical referee in crematorium.		Local authorities	LRFs should ask crematoriums to have plans in place to begin such appointments, but it is likely prior notice will be given if option is likely to be required.

Part 3 – Responding & Recovering

Central Government Arrangements

3.1 Central Government's role during response is set out in *Emergency Response and Recovery* and the *Central Government Concept of Operations (ConOps)*.

3.2 The scale and complexity of a pandemic and excess deaths response will be such that some degree of Central Government support or coordination will be necessary, however local responders remain the basic building block of the response to any emergency.

3.3 Department for Health and Social Care (DHSC) will be the designated Lead Government Department (LGD) in England, with the Devolved Administrations leading on issues within their areas of competence in Scotland, Wales and Northern Ireland. The UK Central Government response will be coordinated through the Cabinet Office Briefing Rooms (COBR). The balance of activity between Central Government and the Devolved Administrations will depend on the nature of the emergency and the terms of the devolution settlements.

3.4 Part 2 of the Civil Contingencies Act 2004 contains the government's generic emergency powers legislation. Emergency powers are a last-resort option for responding to the most serious of emergencies where existing legislative provision is insufficient. They are a mechanism for making temporary legislation in order to prevent, control or mitigate an aspect or effect of the emergency. Emergency regulations must be necessary to prevent, control or mitigate an aspect or effect of the emergency and must be proportionate to the effect or aspect of the emergency they are aimed at addressing. There must be no expectation that Central Government will agree to use emergency powers and local planning and response arrangements must assume that they will not be used.

Coordination with Devolved Administrations

3.5 The Scottish, Welsh and Northern Irish Governments will be included in any Central Government response mechanism, should their citizens or interests be affected by the incident, utilizing the pre-existing mechanisms of cross-government emergency coordination.

3.6 As previously stated, excess deaths planning is devolved within Northern Ireland, Wales and Scotland.

Local Arrangements

3.7 An excess deaths response is most likely to be enacted in coordination with the response to the cause of the deaths e.g. a pandemic. LRFs should clarify how these responses will work in parallel with each other and the resource requirement. An excess deaths sub-group of an already stood up SCG for the cause, is advised with appropriate cells beneath, as recommended above.

3.8 The nature of a pandemic means that large areas of the country will be affected. Should this be the case a Resilience Coordination Group (ResCG) or a number of ResCGs may be established by Central Government in order to add an extra level of coordination in to the response.

Communications

3.9 Communicating with the public is key to establishing the most effective response and recovery to an incident. Any incident involving the death of people particularly on a national scale will generate a thirst for accurate and informative advice. The appetite for information on how the deceased are being treated should not be underestimated. It is likely to become a focus of media reporting at local, regional, and national levels.

3.10 Systems for receiving and disseminating information will need to be robust and capable of moving at a fast pace. Sharing up-to-date information will be vital. If local and regional messages are inconsistent with the information that Central Government is providing they may cause unnecessary distress and alarm to local communities and the bereaved.

3.11 Local, regional, and national communication strategies should seek to raise awareness of the pressures local service providers are likely to be under. Information on potential different ways of working should be factual and accurate. Getting across the message that local management may vary from one area to the next will be important.

3.12 Good practice suggests all organisations and agencies affected by a communications strategy should agree to it. Roles should be allocated and understood. Strong leadership on communications will be vital to the effectiveness of the strategy. Information will not always need to contain large quantities of detail but must be accurate. This is particularly relevant to communication of potential changes to processes affecting how the deceased are treated. Messages will need to be given sensitively and with consideration for the bereaved. It should be made clear when further updates will be made available. Attention should be paid to considering how information can be conveyed to all members of the local community, including those who cannot understand spoken or written English.

3.13 A Central Government communications hub may be activated to assist in news management and media handling. Central Government will want to provide information about why different ways of working are required and factual information about potential options open to local service providers.

3.14 Advice on consistency with other aspects of pandemic communications activity should be sought from the communications hub. The Local Government Association (LGA) and local authorities Coordinators of Regulatory Services have good experience of receiving and disseminating information to local authorities. Existing arrangements would become the hub for local service communications during a pandemic.

3.15 Letting the bereaved know where they can access bereavement, and other support (e.g. financial, legal) will be an important part of local communication strategies. Existing literature should be relied upon and made available in the usual way.

Recovery

3.16 An excess deaths plan will naturally focus on the response however it is vital that consideration is given to recovery. A wider recovery coordination group will most likely be established to deal with the consequences of a pandemic however it is imperative that issues relating to the death management process returning to normal business, are considered within this wider group or through a specific group for excess deaths.

Part 4 - Annex

Annex A – Legislation, Regulations and Guidance

Legislation - Acts

Health and Safety at Work Act 1974
Coroners and Justice Act 2009
Human Tissue Act 2004
The Town and Country Planning (General Permitted Development)(England) Order 2015
Civil Contingencies Act 2004
Pollution Prevention and Control Act 1999
Registration of Burials Act 1864
Local Government Act 1972

Legislation - Regulation

Management of Health and Safety at Work Regulations 1999
Control of Substances Hazardous to Health (COSHH) Regulations 2002
Registration of Births and Deaths Regulations 1987
Town and Country Planning (Environmental Impact Assessment) Regulations 2017
Environmental Permitting Regulations (EPR) 2016
Crematoria Abatement of Mercury Emissions Organisation (CAMEO) Burden Sharing Scheme
Cremation (England and Wales) Regulations 2017
The Water Environment (Water Framework Directive) (England and Wales) Regulations 2017

Guidance

HSE Guidance on Prevention of Infection when Handling the Deceased
Pandemic Influenza: Guidance on the management of death certification and cremation certification
Pandemic Influenza: Guidance on the Operation of the Coroner System in England and Wales
Care and Respect in Death: Good Practice Guidance for NHS Mortuary Staff
HTA Guidance on HTA Licensing of Emergency Mortuaries
Statutory Guidance for Crematoria (Process Guidance Note 5/2 (12))
Cemeteries and Burials: Prevent Groundwater Pollution Guidance 2017
DHSC Health Building Note 20 – Facilities for Mortuary and Post-Mortem Room Services (England and Wales)
Mortuary and post-mortem facilities: Design and Briefing Guidance (Scottish Health Planning Note 16-01)
Groundwater Protection Policy
HTA Licensing of Emergency Mortuaries Guidance 2019
Chief Coroner’s Guidance to Coroners

EU Directives

Water Framework Directive (WFD) - establishing a framework for community action in the field of water policy (2000/60/EC)
Groundwater Directive (GWD) - on the protection of groundwater against pollution and deterioration (2006/118/EC)

Annex B - Glossary of Abbreviations

Abbreviation	Definition
BCP	Business Continuity Plan
C&D	Cleaning and Disinfectant
C3	Command, Control and Coordination
CAMEO	Crematoria Abatement of Mercury Emissions Organisation
CCA	Civil Contingencies Act (2004)
COBR	Cabinet Office Briefing Rooms
ConOps	Concept of Operations
COSHH	Control of Substances Hazardous to Health
DEFRA	Department for Environment, Food & Rural Affairs
DHSC	Department of Health and Social Care
DI	Designated Individual
DWP	Department of Work and Pensions
EA	Environment Agency
EIA	Environmental Impact Assessment
EPR	Environmental Permitting Regulations
EU	European Union
FCO	Foreign and Commonwealth Office
GMC	General Medical Council
GRO	Government Registry Office
GWD	Groundwater Directive
HO	Home Office
HSE	Health and Safety Executive
HTA	Human Tissue Authority
JRLO	Joint Regional Liaison Officer (MOD)
LGA	Local Government Association
LGD	Lead Government Department
LH	License Holder

LRF	Local Resilience Forum
MCCD	Medical Certificate of Cause of Death
MHCLG	Ministry of Housing, Communities & Local Government
MoD	Ministry of Defence
MoJ	Ministery of Justice
NEMA	Former National Emergency Mortuary Arrangements
NHS	National Health Service
ONS	Office of National Statistics
PDR	Permitted Development Rights
PPE	Personal Protective Equipment
ResCG	Resilience Coordination Group
RPE	Respiratory Protective Equipment
SCG	Strategic Coordination Group
SPZ1	Source Protection Zone 1
SPZs	Groundwater Source Protection Zones
TR(E)	Temporary Registration (Emergency)
UK	United Kingdom
WFD	Water Framework Directive
WHO	World Health Organisation