INFECTION CONTROL POLICY FOR CARE OF THE CADAVER

Version 10: March 2025

First Issued: **March 2009**
Review date: **March 2027**

Contents

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1. INTRODUCTION

Last offices is the term used to describe the care given to the deceased patient which is focused on fulfilling religious and cultural beliefs as well as health, safety and legal requirements. There are approximately 600,000 deaths per year in the United Kingdom and about two-thirds occur in hospital, of that less than one percent is associated with a known or suspected infection. This policy sets out the procedures for staff to follow for the management of non-infectious and infectious deceased clients.
On 6th April 2010 changes were made to the Public Health Law; this legislation adopts an all hazards approach.
It requires notification of infections (See appendix 1) or of contamination by chemicals or radiation which doctors believe present, or could present, a significant risk to human health.

2. PURPOSE

The purpose of this policy is to ensure prompt recognition of those patients who pose a risk of infection.

3. SCOPE

This document applies to all staff either employed or contracted within in-patient areas in East Coast Community Healthcare CIC. New staff must receive local induction on the contents of this policy and its implementation

4. DEFINITIONS *(if relevant)*

The following definitions are intended to provide a brief explanation of the various terms used within this policy.

Term	Definition
Policy	A policy is a formal written statement detailing an enforceable set of principles or rules. Policies set the boundaries within which we operate. They also reflect the philosophy of our organisation.
Cadaver	Deceased body

5. RESPONSIBILITIES

- **ECCH Employees** – Are responsible for the implementation of this policy and following the requirements of the policy.

- **Chief Executive of ECCH** – Overall responsibility for the enforcement of this policy lies with the Chief Executive of ECCH

- **ECCH Managers** – Are responsible for monitoring employee compliance with this procedure.

6. POLICY STATEMENT

This policy will be implemented to ensure adherence to safe practice.

7. PROCEDURE

Management of the deceased patient

The deceased should be treated with due respect and dignity appropriate to their religious and cultural background. Last offices can vary according to religious and cultural practices. These may be compromised by the need of specific measures if an infectious disease was associated with death or co-existed at the time of death. Any problems should be discussed with the Consultant in Communicable Disease Control (0300 3038537) who may wish to consult the appropriate priest or religious authority.

Most bodies are not infectious; however, through the natural process of decomposition the body may become a source of potential infection whether previously infected or not; therefore, sensible precautions should be taken routinely. The indiscriminate use of cadaver bags may cause needless anxiety for the bereaved family.
Not all cases of infection will have been identified before death and for this reason; it is strongly recommended that standard precautions are adhered to in all cases. Each patient must have a risk assessment performed to ascertain any potential hazards. All staff who come in contact with any potential infectious hazard must have occupational health clearance.

- Disposable gloves and aprons must be worn when washing and preparing the body.
- Washing the body with soap and water is adequate.
- Dressings, drainage tubes etc. can be removed unless death has occurred within 24 hours of an operation or was unexpected - in which case a post-mortem may be likely so they must be left in situ. If left in situ a note must be made on the undertaker's letter.
- Clean occlusive dressings must be applied to any wounds.
- Profusely leaking orifices may be packed with gauze or cotton wool.
- A copy of Appendix 4 must be attached to the outer covering of everybody.

Additional measures for a known infected patient

The body of a patient who has been suffering from an infectious disease may remain infectious to those who handle it.
Cadaver bags are available from either the undertaker or from the stores department.
The funeral staff must be informed of the potential infectious risk.

Specific Infections (See Appendix 1)

Very High Risk- Group A:

- Where a confirmed VHF case has died while being cared for in a bed isolator, the body should be removed according to the local operational policy.
- Where the body of a confirmed or suspected VHF patient is not in an isolator, staff wearing suitable PPE should place the body in a double body bag. Absorbent material should be placed between each bag and the bag sealed and disinfected with 1000 ppm available chlorine or other appropriate disinfectant. The bag should be labelled as high risk of infection and placed in a robust coffin with sealed joints.

- The national public health agency, UKHSA, should be contacted.
- Viewing and touching prohibited*
- No embalming
- Hygienic preparation banned

Applies to:

- Anthrax
- Lassa, Ebola, Marburg and other viral haemorrhagic fevers
- Yellow fever
- Plague
- Rabies
- SARS* -the 'WHO' guidance currently states that family may view the body if they wear personal protective equipment
- Septicaemia due to invasive Group A streptococcal infection, if patient has **not** had 24 hours of appropriate antibiotic therapy
- Smallpox

With the exception of Group A streptococcal septicaemia, the above infections are rare in the UK and, if they were to occur, the case would almost certainly die in hospital.

High risk- Group B

- The bereaved should be warned of the potential infection risk. If they wish to carry out ritual washing or preparation of the body this should be done under supervision with advice about the use of standard precautions.
- A body bag must be used for Typhus, CJD and other transmissible spongiform encephalopathies (TSE's) and considered for others if there is leakage of body fluids
- Embalming should not be done

Applies to:

- CJD and other transmissible spongiform encephalopathies (TSE's)
- Typhus

And for the following diseases only if there is seepage of body fluids:

- Hepatitis B
- Hepatitis C
- Other blood-borne Hepatitis' e.g. Hepatitis D
- HIV/AIDS

Hepatitis B – Group B

Hepatitis B is a blood-borne virus and is extremely infectious if it enters the body through skin penetration such as a needle stick injury. If there is leakage of body fluids, bodies suspected of being infected should be handled with great care, all staff must wear the required personal protective equipment. The bereaved should be warned of the potential risk of infection and advised on precautions that should be taken if they wish to touch the body.

If they wish to carry out any ritual washing, they should be supervised and advised on the use of standard precautions. Any staff who have not been vaccinated or have not gained immunity to hepatitis B should seek occupational health advice.

Hepatitis C, D and G – Group B

Hepatitis C, D and G are transmitted by the same routes as hepatitis B. No vaccine is yet available. Full precautions should be taken as for hepatitis B. Hepatitis D does not occur without hepatitis B.

HIV/AIDS –Group B

Standard precautions should be adequate to prevent transmission of HIV/AIDS. Other infectious organisms may also be present and co-infection with tuberculosis and cryptosporidiosis must be considered.

Body bag is advised only if there is leakage of body fluids

Medium risk- Group C

- Hygienic preparation of the body is permitted
- Viewing and touching is allowed
- Embalming may be carried out
- Standard precautions still need to be taken

Applies to:

- Cholera
- Diphtheria
- Dysentery (amoebic or bacillary)
- Meningococcal disease (untreated)
- Typhoid and Paratyphoid fever
- Relapsing fever
- Scarlet fever
- Tuberculosis
- Brucellosis
- Salmonellosis

Tuberculosis- Group C

In patients with respiratory tuberculosis, it is recommended that the face of the cadaver be covered with a disposable facemask when being handled to prevent any aerosol formation as air is expelled from the lungs.

Gastrointestinal Infections- Group C

Leakage of faeces from bodies is common and all who handle them should use standard precautions. Careful cleaning up of all leakages and scrupulous hand washing is important. These infections include the dysenteries, salmonellosis and cryptosporidiosis.

Low risk-Group D

- Body bag not required
- Hygienic preparation of the body is permitted
- Body can be handled- viewing and touching is allowed

- Embalming may be carried out
- As the presence of infectious agents is not suspected, notably hepatitis B and C, HIV/AIDS and tuberculosis, it is still important that the precautions specified in the Control of Substances Hazardous to Health should be followed for handling all bodies, but especially standard infection control procedures such as the use of appropriate protective clothing and the washing of hands is required.

Septicaemia - Group D (unless *untreated* Meningococcal or Group A Streptococcal)

Only the septicaemias caused by meningococcal or Group A streptococcal pose a risk, (unless they have been treated with appropriate antibiotic therapy) and these should be handled with care. The blood and other body fluids are infectious and can infect those who handle the body or clean up contaminated surfaces, even through apparently trivial injuries or other breaks in the skin surfaces. Any accidents or tears in gloves must be reported immediately to a senior member of staff. If necessary, a consultant microbiologist should be consulted.

MRSA – Group D

This infection is not a problem but can cause concern amongst funeral directors. Standard precautions are all that is required.

SARS-COV-2 (Covid 19) Group D

Those handling bodies should be aware that there is likely to be a continuing risk of infection from body fluids and tissues where COVID 19 infection is suspected or confirmed. Although the risk of transmission is lower than for living patients, action should be taken to mitigate that risk. Standard infection control precautions and transmission based precautions should be used to ensure safe ways of working when handling the deceased.

Body bags should be used if there are large quantities of body fluids present.

A ‘Notification of Death’ label and a ‘Danger of Infection’ label should be attached discreetly to the outside of the bag. Neither label should state the diagnosis; this is confidential information and an individual’s right to confidentiality continues after death. Relatives may be unaware of the true nature of the infection but nevertheless must be advised of any precautions they should take. If relatives wish to carry out ritual preparation of the body, it should be done under supervision, ensuring that standard precautions are observed. It is the responsibility of the certifying clinician to ensure the funeral directors have sufficient information about the level of risk of infection and the level/type of precautions required.

Once the body is sealed in the body bag, protective clothing is no longer required.

Relatives and friends who wish to view the body should do so as soon after the death as possible. The bag can be opened by a member of staff wearing disposable gloves and apron, but the relatives should be told there is some risk of infection and in some cases the bag should not be opened e.g. if the patient suffered from Anthrax, Plague, Rabies and Viral Haemorrhagic Fever.

8. MONITORING AND REVIEW

This document will be reviewed by the Infection Prevention & Control Committee (IPACC), March 2025, or sooner if changes in legislation occur or new best practice evidence becomes available.

9. REFERENCES *(if relevant)*

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algorithm-and-guidance-on-management-of-patients/risk-assessment-and-immediate-management-of-viral-haemorrhagic-fevers-contact-high-consequence-infectious-diseases-in-acute-hospitals#appendix-8-cleaning-and-decontamination (Accessed 26/02/2025)

10. AUTHOR

Infection Prevention & Control Team March 2025

11. APPENDICES

1. **Transmission based precautions**
2. **Hazard Notification**

Appendix 1

Application of transmission-based precautions to key infections in the deceased

The causative agents for the key infections listed below have been arranged according to the most likely route of transmission, taking account of the activity when handling the deceased, eg through post-mortem and embalming.

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can postmortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Airborne Small particles that can remain airborne with potential for transmission by inhalation							
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes[2]	Yes[3]	Yes	Yes[3]
Middle East respiratory syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Severe acute respiratory syndromes (SARS)	eg SARS coronavirus	3	Yes	Yes	Yes[3]	Yes	Yes[3]
Droplet Large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose or eyes)							
Meningococcal septicaemia (meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes[5]	Yes	Yes[5]
Flu (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes[5]	Yes	Yes[5]
Diphtheria	*Corynebacterium diptheriae*	2	No	Yes	Yes	Yes	Yes
Contact Either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes[5]	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	No[6]	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No[6]	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No[6]	Yes	Yes	Yes	Yes
Enteric fever (typhoid/ paratyphoid)	*Salmonella typhi/ paratyphi*	3	No[6]	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis*	3	No	Yes	Yes[4]	Yes	Yes[4]
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxinproducing *E.coli* (eg O157: H7)	3	No[6]	Yes	Yes[4]	Yes	Yes[4]

Infection	Causative agent	Hazard group	Is a body bag needed[1]?	Can the body be viewed?	Can postmortem be carried out?	Can hygienic treatment be carried out?	Can embalming be carried out?
Contact Either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired immune deficiency syndrome (AIDS)-related illness	Human immunodeficiency virus	3	No	Yes	Yes[7]	Yes	Yes[7]
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[8]	No	No

Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes[7]	Yes	Yes[7]
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	Specifically Lassa fever, Ebola, Marburg, Crimean-Congo haemorrhagic fever viruses	4	Yes[9]	No	No	No	No
Contact Either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							
Transmissible spongiform encephalopathies (eg CJD)	Various prions	3	Yes	Yes	Yes[10]	Yes	No

Key

Red Minimise procedures or handling of the deceased

Yellow TBPs are necessary when carrying out procedures or handling the deceased

The highlighted areas indicate an increased level of risk associated with the infection to workers (with areas in red posing increased risk) and therefore require additional control measures when handling the deceased.

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is, or is likely to be, leakage of body fluids.

[2] With appropriate measures to deal with potential release of aerosols (eg place cloth or mask over mouth when moving the deceased).

[3] With appropriate measures to deal with aerosol-generating procedures.

[4] With measures to minimise environmental contamination (because of low infectious dose; ie the amount of pathogen or number of bacteria required to cause an infection is low).

[5] With appropriate measures to prevent exposure of mucosal surfaces (eg a physical barrier to protect eyes, mouth and nose, such as a facemask or visor).

[6] Although illness may have increased likelihood of leakage of body fluids.

[7] With appropriate robust measures for the use of sharps (eg minimise use or use safer sharps devices).

[8] Before undertaking a procedure, the rationale for a post-mortem should be carefully considered where anthrax infection is suspected, particularly where examination may increase the potential for aerosol generation.

[9] With double body bag.

[10] With appropriate measures to minimise percutaneous injury and contamination of work area, and to help with decontamination (eg high-level sharps control or dedicated equipment).

Hazard groups

The Approved List of biological agents (www.hse.gov.uk/pubns/misc208.pdf) provides the approved classification of biological agents into hazard groups (as referred to in COSHH). The hazard groups are defined in the following table; when classifying a biological agent it should be assigned to one of these four groups according to its level of risk of infection to humans.

Group	Definition
Group 1	Unlikely to cause human disease
Group 2	Can cause human disease and may be a hazard to employees; it is unlikely to spread to the community and effective prophylaxis or treatment is usually available
Group 3	Can cause severe human disease and may be a serious hazard to employees; it may spread to the community, but effective prophylaxis or treatment is usually available
Group 4	Causes severe human disease and is a serious hazard to employees; it is likely to spread to the community and usually no effective prophylaxis or treatment is available

Notification of reportable diseases

Certain diseases are reportable under national legislation. Please refer to the relevant legislation for notifiable diseases:
England – Health Protection (Notification) Regulations 2010,http://www.legislation.gov.uk/uksi/2010/659/schedule/1/made

Wales – Health Protection (Notification) (Wales) Regulations 2010,http://www.legislation.gov.uk/wsi/2010/1546/schedule/1/made
Scotland – Public Health etc (Scotland) Act 2008, ttp://www.legislation.gov.uk/asp/2008/5/schedule/1

Appendix 2

Hazard notification sheet

1	**Name of deceased**			
2	**Date and time of death**			
3	**Source (hospital, ward or other)**			
4 Infection risk from the deceased[1]				
4a	Does the deceased present an infection risk? (Ring as appropriate)			
	Yes	Suspected	None suspected	
4b	If yes, what are the likely routes of transmission? (Ring all that apply)[2]			
	Airborne	Droplet	Contact	
4c	Infection (if permitted to disclose)[3]			
4d	Provide any relevant information to enable the deceased to be handled safely[4]			
5 Condition of the deceased[5]				
5a	Is the deceased leaking body fluids? Please provide details			
5b	Have accessories that present a risk of sharps injury been removed?			
5c	If yes, have the puncture points been covered or sealed?			
5d	If no, please provide details and location			
5e	Does the deceased have an implantable device? (Ring as appropriate)			
	No	Yes and switched off	Yes but not switched off	
5f	If yes, please provide details and location			
5g	Was the deceased receiving radiotherapy? (If yes, please provide details)			
6	**Signed**[6]			
	Print name			
	Institution			

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc Act 1974). This form provides one means of sharing the pertinent information.

Notes

[1] Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

[2] When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

[3] If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

[4] In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (eg embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

[5] In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, eg sharp medical devices or implantable devices (eg pacemakers), their location and whether they need to be removed.

In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (eg community setting), the doctor with knowledge of the deceased's condition is asked to sign.

12. EQUALITY & DIVERSITY IMPACT ASSESSMENT

In reviewing this policy, the HR Policy Group considered, as a minimum, the following questions:
- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Blank version of the full Equality & Diversity Impact assessment can be found here:

http://eccho/Home/FormsGuidance.aspx?udt_575_param_index=E&udt_575_param_page=2

13. DOCUMENT CONTROL

Version Date	Version No.	Author/ Reviewer	Comments
2011	3	IP&C	Format changes
2013	4	IP&C	Format changes
2015	5	IP&C	
2017	6	IP&C	
2019	7	IP&C	References
2021	8	IP&C	Updated
2023	9	IP&C	References, updates
2025	10	IP&C	References

DOCUMENT CONTROL SHEET

Name of Document:	Infection Control Policy for Care of the Cadaver
Version:	10
File Location / Document Name:	ECCHO
Date Of This Version:	March 2025
Produced By (Designation):	Infection Prevention & Control Team
Reviewed By:	IPACC

Synopsis And Outcomes Of Consultation Undertaken:	Changes relating to relevant committees/groups involved in ratification processes.
Synopsis And Outcomes Of Equality and Diversity Impact Assessment:	No specific issues. National EIA gives more details on measures to reduce HCAIs.
Ratified By (Committee):-	IPACC
Date Ratified:	March 2025
Distribute To:	Clinical Staff
Date Due For Review:	March 2027
Enquiries To:	infectionprevention@ecchcic.nhs.uk
Approved by Appropriate Group/Committee **Approved by Policy Group** **Presented to IGC for information**	☐ Date: ☐ Date: ☐ Date: