ESSEX HEALTH PROTECTION UNIT

Part of the

INFECTION CONTROL GUIDELINES FOR FUNERAL DIRECTORS

Issued July 2004
Revised December 2012

CONTENTS

SECTION A – INTRODUCTION AND CONTACTS 4
A1. Introduction 4
A2. Contact List 5
SECTION B – INFECTION, ITS CAUSES AND SPREAD 6
B1. Infection and its Control 6
SECTION C – STANDARD PRINCIPLES OF INFECTION CONTROL 8
C1. Standard Principles of Infection Control (Universal Precautions) 8
SECTION D – MANAGEMENT OF SHARPS INJURIES 11
D1. Management of Sharps 11
SECTION E – CLINICAL PRACTICE 14
E1. Guidelines for Handling Cadavers with Infections 14
E2. Guidelines for Viewing Infected Bodies 15
E3. Confidentiality 15
E4. Cleaning of Instruments 16
E5. Premises 16
E6. Vehicles 16
E7. Waste Disposal 17
SECTION F – VACCINATIONS 18
SECTION G – REFERENCES 19
SECTION H – APPENDICES 20
APPENDIX 1 - GUIDELINES FOR HANDLING CADAVERS WITH INFECTIONS 21
APPENDIX 2 - INFECTION CONTROL NOTIFICATION SHEET 23
APPENDIX 3 - DECLARATION OF CONTAMINATION STATUS 24

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION A – INTRODUCTION AND CONTACTS

A1. Introduction

There are some infectious conditions in a cadaver that may pose a hazard to the people who handle it. These guidelines have been written for Funeral Directors and Embalmers whose occupational contact with cadavers may put them at a greater risk than normal of contracting an infection.

In this document the term ‘embalming’ refers to both arterial and cavity embalming. Preparation of a body will also include one or all of the following: septal suturing (or equivalent), packing, washing and handling of the cadaver. The greatest risk in these procedures is from those which require the use of sharp instruments, with the potential risk of injury to the embalmer during preparation of the body.

At the end of this document there is a list of infections, with advice for body bagging, viewing, hygienic preparation and embalming. The table is meant as guidance only, and additional advice may be sought from the Essex Health Protection Unit (EHPU).

It is important to remember that risks can be minimised by following good basic infection control precautions. These precautions should be used in all instances, as it may not be known if a given cadaver harbours an infection or not.

A2. Contact List

Infection Control advice can be obtained from:

Essex Health Protection Unit
8 Collingwood Road
Witham
Essex
CM8 2TT

The main office telephone number is: 0845 155 0069.

The Consultants in Communicable Disease Control (CsCDC) and Communicable Disease Control Nurses (CDCNs) are contactable via this number. The fax number is 01376 302278.

Advice is also available on the HPA website www.hpa.org.uk.

Users are encouraged to ensure they have access to this site as it has advice and information on a wide range of local communicable disease issues, and during incidents will be updated at least daily with the current state of affairs.

Out of working hours – for URGENT communicable disease enquiries contact 01245 444417, and ask the operator to page the on-call Public Health Person.

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION B – INFECTION, ITS CAUSES AND SPREAD

B1. Infection and its Control

1.1 What is Infection?

Infection is a pathological process, which involves the damaging of the body tissues by micro-organisms or by toxic substances produced by these organisms. It must be remembered that the mere presence of micro-organisms in a site does not necessarily indicate that an infection is there. Signs and symptoms usually accompany infection, for example pain, swelling, redness, production of pus and/or fever.

1.2 What Causes Infection?

Pathogenic micro-organisms cause infection. They may be classified as follows:

Bacteria - are minute organisms about one-thousandth to five-thousandth of a millimetre across. They are susceptible to a greater or lesser extent to antibiotics.

Viruses - are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

Pathogenic Fungi - can be either moulds or yeasts. For example, a mould which causes infections in humans is *Trichophtyon rubrum* which is one cause of ringworm and which can also infect nails. A common yeast infection is thrush caused by an organism called *Candida albicans*.

Protozoa - are microscopic organisms, but larger than bacteria. Free-living and nonpathogenic protozoa include amoebae and paramecium. Examples of medical importance include *Giardia lamblia*, which causes enteritis (symptoms of diarrhoea).

Worms - are not always microscopic in size but pathogenic worms do cause infection and some can spread from person-to-person. Examples include threadworms and tapeworms.

Prions - are infectious protein particles. Examples include New Variant Creutzfeldt-Jakob Disease (vCJD).

1.3 The Spread of Infection

One feature that distinguishes infection from all other diseases is that it can be spread, i.e. one person can 'catch' it from another or via vectors (e.g. crawling or flying insects), or fomites (inanimate objects).

1.4 Modes of Spread

The modes of spread of infection can be classified as follows:

Direct Contact. Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. chickenpox, sexually transmitted infections etc.).

Inhalation. Inhalation spread occurs when microbes exhaled or discharged into the atmosphere by an infected person are inhaled by and infect another person. The common cold and influenza are often cited as examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses.

Ingestion. Infection can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal-oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, *Salmonella*, *Campylobacter*.

Inoculation. Inoculation infection can occur following a "sharps" injury when blood contaminated with, for example, Hepatitis B virus, is directly inoculated into the blood stream of the victim, thereby causing an infection. Bites from humans can also spread infection by the inoculation mode.

Indirect. Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogenic microbes from the source of infection to another person e.g. hands, fomite or vector.

> A **fomite** is defined as an object which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person. Examples of potential fomites are bedpans, urinals, thermometers, oxygen masks or practically any inanimate article.
>
> **Vectors**. Crawling and flying insects are an obvious example of intermediate carriers and need to be controlled. Insect bites may cause infections such as malaria.

Hands. The hands of health and social care workers are probably the most important vehicles of cross-infection. The hands of patients can also carry microbes to other body sites, equipment and staff.

Air. Some infections can be spread by aerosol e.g. Chickenpox, Mumps and Measles.

Diseases in the living are a far greater hazard to health than diseases in the dead.

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION C – STANDARD PRINCIPLES OF INFECTION CONTROL

C1. Standard Principles of Infection Control (Universal Precautions)

For persons dealing with the recently deceased, regardless of which infectious agents may be present, observance of Control of Substances Hazardous to Health (COSHH) procedures, the covering of cuts or lesions with waterproof dressings, careful cleansing of any injuries sustained during procedures and particularly the use of appropriate protective clothing for the procedure will greatly reduce the risk of acquiring infection.

Blood and body fluids may contain blood-borne viruses or bacterial pathogens that may present a risk to the Funeral Director or Embalmer. In known cases of infection the Funeral Director or Embalmer should be informed of any risk to him and what specific precautions he needs to take. This is the responsibility of the certifying doctor. If a body is removed without certification, e.g. from a Nursing/Residential Home, under current practice it remains the responsibility of the certifying doctor to ensure that any relevant information on infection risk is made known to the Funeral Director or Embalmer.

It is not always possible to know which bodies are infected and so there are certain precautions that must be taken when handling all bodies.

The process of embalming exposes the embalmer to a much greater risk of contamination from body fluids than other procedures do.

Body fluids include:

- Tissue fluid (e.g. fluid released when skin-slip occurs)
- Semen
- Vaginal secretions
- Cerebro-spinal fluid
- Amniotic fluid
- Pericardial and pleural fluids
- Faeces
- Urine
- Vomit (purge)
- Sweat
- Blood.

The Standard Principles of Infection Control include:

Handwashing

- Hands should be washed after all procedures, after delivery or collection of the cadaver, after removing gloves, before handling any food and before leaving work for the day

- If the skin is contaminated with blood or body fluid, this should be washed off immediately with soap and hot running water.

Protective Clothing - General

- Unpowdered Latex Gloves - should be worn for direct skin contact with a body, for contact with body fluids or for handling of clothing contaminated with body fluids. Gloves should be disposed of after each use as infectious waste or as appropriate

- For individuals who may be sensitive to latex, it is advised that synthetic gloves are used. Nitrile gloves are a suitable example of synthetic gloves

- Plastic Aprons – long-length plastic aprons should be worn wherever there is a risk of contamination by blood or body fluids

- Protective Eyewear - should be worn if there is a risk of splashing of blood or body fluids onto the face.

Protective Clothing - Embalming

All usual clothing should be removed and replaced with:

- Overalls or basic suit which is either disposable or can be washed at a high temperature

- A full-length gown

- Wellington-type, chemical-proof, non-slip boots

- Plastic apron, long enough to overlap boots

- Protective waterproof sleeves

- Heavy duty disposable gloves (latex gloves can be worn under heavy duty gloves for added protection)

- Face/eye protection (goggles/protective spectacles/face visor).

After embalming is completed, or at the end of the day, a full shower or wash should be taken if desired or when necessary, if contamination with body/embalming fluids has occurred.

Skin Care

- All cuts and abrasions should be covered with waterproof dressings
- Nails should be cut short and clean
- Nail varnish and false nails should not be worn during embalming, as they harbour micro-organisms
- Jewellery should be kept to a minimum at work to allow thorough handwashing.

Spillages

- These must be dealt with immediately
- Disposable gloves and apron should be worn
- All spills of blood, or body fluid visibly stained with blood, should be cleaned with 10,000 ppm available chlorine solution or Sodium Dichloroisocyanurate (NaDCC) granules (e.g. Presept, Haztabs, Sanichlor) or an appropriate spillage kit. Dispose of all equipment used and spill as infectious waste.
- The area should then be washed with detergent and hot water, and allowed to dry.

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION D – MANAGEMENT OF SHARPS INJURIES

D1. Management of Sharps

- Particular care should be taken when handling sharp instruments e.g. scalpel blades, and appropriate protective clothing should be worn throughout
- Every effort should be made to use safer needles such as needleless connectors, self-resheathing needles and blunted surgical needles.
- Sharps bins should not be filled more than three-quarters full, should be closed securely and marked/labelled to identify its source before disposal by incineration
- Sharps must not be passed directly from hand-to-hand, and handling should be kept to a minimum
- Used sharps must be discarded into a sharps container (conforming to UN3291 and BS 7320 standards) at the point of use by the user. These must not be filled above the mark that indicates that they are full
- Containers must be disposed of by the licensed route in accordance with National Waste policy
- Sharps containers should be available at each location where sharps are used
- The opening of the sharps container must be closed when being carried or when left unsupervised to prevent spillage or tampering
- Sharps containers should be placed on a level stable surface
- Assemble sharps containers carefully by following the manufacturer's instructions
- Carry sharps containers by the handle - do not hold them close to the body
- Never leave sharps lying around
- Do not try to retrieve items from a sharps container
- Do not try to press sharps down to make more room
- Lock the container when it is three-quarters full using the closure mechanism
- Label sharps containers with the source details prior to disposal

- Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do not place inside yellow clinical waste bags.

Sharps Injuries/Splashing Injuries

This involves:

- Inoculation of blood by a needle, scalpel blade, suture needle or other sharp
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes or mouth
- Contamination where clothes have been soaked by blood.

ACTION:

1. Gently encourage bleeding from the wound (if not bleeding freely)
2. Wash the wound in soap and warm running water, but do not scrub the area
3. Cover the wound with a waterproof dressing
4. Skin, eyes or mouth: wash in plenty of water
5. Ensure the sharp is disposed of safely
6. Report the incident to immediate supervisor
7. Attempt to identify source of the needle/sharp
8. The person who sustained the wound should see their General Practitioner or attend the Accident and Emergency Department as soon as possible
9. Complete an accident report form, and record all information in the accident book.

If the deceased is known to be infected with a blood-borne virus, seek medical advice immediately, by telephone from the Consultant in Communicable Disease Control. In some circumstances e.g. exposure to HIV positive blood, treatment is best given within an hour.

What to do after a……

SHARPS INJURY

Directions for the management of needlestick injuries, and penetrating wounds, contaminated with blood or blood-stained body fluids

Wash cuts thoroughly with soap and warm water, then gently encourage to bleed. Apply a dressing if necessary.

Splashes to the eyes or mouth should be thoroughly rinsed with running water

Report incident to your manager immediately (if applicable)

Your medical advisor should: -

a) Take a history and make a risk assessment
b) Review your Hepatitis B vaccine status
c) Take 10ml clotted blood from the recipient and, if possible, the 'source' (with informed consent)
d) Send the samples to the microbiology department marked 'needlestick Injury'
e) Ensure appropriate follow-up

Complete an accident form

Insert your local arrangements

Please Note

If the source is known or a risk of having HIV the injured person should contact Accident & Emergency, and attend if possible within the hour

---

Remember
Be prepared – If you are at risk of exposure – get immunised against Hepatitis B Virus

Tel: In hours:- Your GP or Occupational Health Dept

Tel: Out of Hours:- Your local A&E Department

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION E – CLINICAL PRACTICE

The clinical practices included in the section are:

- Guidelines for Handling Cadavers with Infections
- Guidelines for Viewing Infected Bodies
- Confidentiality
- Cleaning of Instruments
- Premises
- Vehicles
- Waste Disposal.

E1. Guidelines for Handling Cadavers with Infections

As well as using body bags for some known infections (Please refer to Appendix 1), some hospitals have adopted the use of body bags for all deceased patients, as a continuation of universal precautions. Others are using body bags where a possibility of continued body fluid leakage is expected. Funeral Directors should be routinely informed if the body poses an infectious risk (Refer to a sample notification sheet in Appendix 2.) It should not be assumed by the Funeral Directors that the use of a body bag alone implies the cadaver is infected.

In the table in Appendix 1, the list of infections has been arranged alphabetically for ease of reference.

Appendix 1 is adapted from the advice of the HSE (2005) and CDR (1995). It gives guidance as to the need for a body bag and advises if the deceased can be viewed, hygienically prepared and embalmed. The list of conditions/infections is not exhaustive, and additional advice may be sought from the EHPU.

E2. Guidelines for Viewing Infected Bodies

Where relatives have expressed a wish to view/kiss the body, and, providing that there is no obvious risk of exposure to potentially infected body fluids, the head, shoulders and arms may be exposed (making the body bag unobtrusive).

This advice only applies to most known or suspected contagious diseases.

There are, however, exceptions as in the case of very serious infections such as:

- Anthrax
- Plague
- Rabies
- SARS
- Smallpox
- Transmissible Spongiform Encephalopathies (TSE)(where necropsy has been performed)
- Viral Haemorrhagic Fever
- Yellow Fever.

In addition, there may be occasions, such as severe trauma, or decomposition of bodies, when Funeral Directors, in discussion with families, advise against viewing.

E3. Confidentiality

Confidentiality should be observed throughout all aspects of funeral service and particularly when any infectious case is encountered.

Funeral directors are not always informed of the specific diagnosis or cause of death of the bodies they prepare for burial or cremation. In cases where it is felt necessary to preserve confidentiality, funeral directors may be told a cadaver carries a measure of risk without giving a specific diagnosis. In this circumstance it is the responsibility of the certifying clinician (who should seek infection control advice if necessary) to ensure that the risk is correctly quantified. Those refusing to disclose a diagnosis have a responsibility for ensuring that funeral directors are given sufficient information to protect themselves and their staff (COSHH Regulations 1994, Bakshi 2001, CMO 1988). Inaccurate or insufficient information may result in families being denied the right to view a body.

Denying relatives the opportunity to view their deceased can be a source of great distress. If there is any doubt as to the validity of the information given to a Funeral Director, from whatever source, it is strongly recommended that they seek advice from a member of the EHPU.

E4. Cleaning of Instruments

All instruments used for embalming or preparing bodies for the funeral should be cleaned in warm water (if the water temperature is higher than “hand-hot” it may fix protein onto instruments) and detergent to remove blood and other deposits then disinfected by boiling for 5 minutes or soaking in a phenolic disinfectant for 20 minutes. An autoclave, if available, provides excellent decontamination.

If equipment/instruments need attention by an external contractor, decontamination should take place and a Certificate of Decontamination should be completed. (Refer to Appendix 3 for a sample form.)

E5. Premises

Walls, ceilings, floors and ledges should be non-porous and easily washable where there is a possibility of fluid spillage. Surfaces that become contaminated should be cleaned immediately following use with hot water and detergent. The use of disinfectant is only necessary when surfaces are contaminated with potentially infectious materials such as faeces, pus or blood.

Protective waterproof and chemical-proof gloves and plastic apron must be worn whilst handling disinfectants and when cleaning contaminated surfaces. Use of chemicals and disinfectants should comply with the COSHH Regulations and to the more recent REACH Regulation. The latter is a new European Union Regulation concerning the Regulation, Evaluation, Authorisation and restriction of Chemicals (REACH). It came into force on the 1st June 2007, and replaces a number of European directives and regulations with a single system.

All body-handling areas should have a handwash basin with liquid dispensed soap and disposable paper towels.

E6. Vehicles

All removal vehicles should carry a supply of boots, overalls, gloves and body bags. There should also be equipment and materials to clear away and deal with any spillages.

The interior of the vehicle should be constructed so that it can be thoroughly washed and disinfected whenever it becomes contaminated with body fluids.

Hearses and removal ambulances should be easily cleanable.

Removal shells must be constructed in a material that prevents leakage of body fluids and should be washed and disinfected after use.

All other equipment used in the removal of bodies should be of a washable material and washed and disinfected if visibly contaminated.

E7. Waste Disposal

All waste material from the preparation room or embalming theatre is potentially infectious and should be dealt with as hazardous waste taking into consideration the requirements of the Environmental Protection Act - The Controlled Waste Regulations and the Special Waste Regulations, and The Safe Management of Healthcare Waste: Health Technical Memorandum 07-01.

- Staff who generate hazardous waste have a duty of care to ensure it is correctly segregated, sealed and stored before collection for incineration. The collection of hazardous waste should be arranged through a licensed disposal contractor

- Anything that may be contaminated with body fluids e.g. gloves, aprons etc. should be disposed of as infectious waste

- Blood and waste embalming fluids can be disposed of to drain provided this discharges directly to the foul sewerage system

- You will need to make arrangements for the safe handling and transport of soiled linens or clothes that are to be returned to hospitals or relatives.

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION F – VACCINATIONS

All staff must ensure their immunisations are up to date according to the national schedule. .

If this is not the case staff should consult their GP.

In addition

- Hepatitis B. It is recommended that all staff should receive an accelerated course of immunisation against Hepatitis B including a blood test to confirm that the body has produced antibodies to Hepatitis B.

- The British Institute of Embalmers advise Typhoid (monovalent) and Hepatitis A vaccine.

It is the responsibility of the employer to ensure that their staff are protected; this means there should be special arrangements in place with an occupational health service, local clinic or similar. General practitioners are not obliged to offer vaccines required for employment purposes to their patients.

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION G – REFERENCES

CDPH (2001). Code of practice for funeral workers: managing infection risk and body bagging. Bakhshi SS. Communicable Disease and Public Health. Vol. 4: no. 4: 283-7.

CDR (1995). The infection hazards of human cadavers. Communicable Disease Report. Healing TD, Hoffman PN, Young SEJ Vol 5: No 5

COSHH (1988) Control of Substances Hazardous to Health Regulations Statutory Instrument No 1657. HMSO, London

EPA (1991) Environmental Protection Act. The Controlled Waste (Registration of Carriers and Seizure of Vehicles) Regulations. Statutory Instrument No 1624. HMSO

EPA (1996) Environmental Protection Act. The Special Waste Regulations. Statutory Instrument No 972. HMSO

HSE (2005) Controlling the risks of infection at work from human remains. HSE 06/2005

HSE (2006) REACH Regulations – (EC) 1907/2006.

HTM07-01 (March 2011) Safe management of healthcare waste: Health Technical Memorandum 07-01. Department of Health. (Note: this document supersedes the 2006 edition)

WHO (2004) Practical guidelines for Infection Control in Healthcare Facilities: http://www.wpro.who.int/sars/docs/practicalguidelines/dec2004/cover_page.pdf

ESSEX HEALTH PROTECTION UNIT
INFECTION CONTROL GUIDELINES
FOR FUNERAL DIRECTORS

SECTION H – APPENDICES

APPENDIX 1 –

GUIDELINES FOR HANDLING CADAVERS WITH INFECTIONS

Adapted from HSE 2005 and CDR 1995.

Infections	Is a body bag required?	Can the body be viewed?	Can hygiene preparations be carried out?	Can Embalming be carried out?
Acute Encephalitis	No	Yes	Yes	Yes
Acute Poliomyelitis	No	Yes	Yes	Yes
Anthrax	Adv	No	No	No
Chickenpox/Shingles	No	Yes	Yes	Yes
Cholera	No	Yes	Yes	Yes
Clostridium difficile (C.Diff)	No#	Yes	Yes	Yes
Cryptosporidiosis	No	Yes	Yes	Yes
Dermatophytosis	No	Yes	Yes	Yes
Diphtheria	Adv	Yes	Yes	Yes
Dysentery (Bacillary)	Adv	Yes	Yes	Yes
Food Poisoning	No	Yes	Yes	Yes
Hepatitis A	No	Yes	Yes	Yes
Hepatitis B/C	Yes	Yes	Yes	No
HIV/AIDS	Adv	Yes	No	No
Invasive Group A Streptococcal Infection (including Scarlet Fever)	Yes	No	Yes	No
Legionellosis (Legionnaires' Disease)	No	Yes	Yes	Yes
Leprosy	No	Yes	Yes	Yes
Leptospirosis (Weil's Disease)	No	Yes	Yes	Yes
Lyme Disease	No	Yes	Yes	Yes
Malaria	No	Yes	Yes	Yes
Meningococcal meningitis (with or without septicaemia)	Adv	Yes	Yes	Yes
Meticillin resistant *Staphylococcus aureus* (MRSA)	No	Yes	Yes	Yes
Mumps	No	Yes	Yes	Yes
Non- meningocaoccal meningitis	No	Yes	Yes	Yes
Ophthalmia neonatorum	No	Yes	Yes	Yes
Orf Disease	No	Yes	Yes	Yes
Plague	Yes	No	No	No
Psittacosis	No	Yes	Yes	Yes

Q Fever	No	Yes	Yes	Yes
Rabies	Yes	No	No	No
Relapsing Fever	Adv	Yes	Yes	Yes
Rubella	No	Yes	Yes	Yes
SARS	Yes	Yes	No	No
Smallpox	Yes	No	No	No
Tetanus	No	Yes	Yes	Yes
Transmissible Spongiform Encephalopathy (TSE including CJD, vCJD etc)	Yes	Yes (No where necropsy has been performed)	Yes	No
Tuberculosis (TB)	Adv	Yes	Yes	Yes
Typhoid fever	Adv	Yes	Yes	Yes
Typhus	Adv	No	No	No
VHFs including Haemorrhagic Fever with Renal Syndrome	Yes	No	No	No
Whooping Cough	No	Yes	Yes	Yes
Yellow fever	Yes	No	No	No

Adv = Bagging is advisable and may be required by local health regulations.
# Body bag not required, unless there has been faecal leakage.

Appendix 2
Infection control notification sheet

Name of deceased		
Date and time of death		
Source Hospital and ward		
The deceased's remains are a potential source of infection:		
Yes	Unknown	(Ring as appropriate - see note 1 below)
If yes (see note 2), the remains present a risk of transmission by: (ring as appropriate)		
Inoculation	Aerosol	Ingestion
Instructions for handling remains (tick as appropriate)		
Body bagging is necessary		
Viewing is not recommended		
Embalming presents high risk, eg HIV		
Signed (note 3)		
Print name		
On behalf of		(hospital/mortuary/general practitioner)

Notes

Note 1: Not all infected patients display typical symptoms; therefore some infections (including blood-borne viral infections) may not have been identified at the time of death.

Note 2: In accordance with health and safety law.

Note 3: In hospital cases, the doctor certifying death, in consultation with ward nursing staff, is asked to sign this notification sheet; where a post mortem examination has been undertaken, the pathologist (or qualified Anatomical Pathology Technologist) is asked to sign this sheet; in non-hospital situations, the doctor certifying death is asked to sign this sheet.

APPENDIX 3 –

DECLARATION OF CONTAMINATION STATUS

Figure 4 Sample Form – declaration of contamination status

From (consignor): _____ To (consignee): _____

Address _____ Address _____

_____ _____

_____ _____

Reference _____ Reference _____

Emergency tel _____

Type of equipment _____ Manufacturer _____

Description of equipment _____ _____

Other identifying marks _____ _____

Model No. _____ Serial No. _____

Fault _____

Is the item contaminated? Yes* ☐ No ☐ Don't know ☐

*State type of contamination: blood, bodily fluids, respired gases, pathological samples, chemicals (including cytotoxic drugs), radioactive material or any other hazard _____

Has the item been decontaminated? Yes† ☐ No‡ ☐ Don't know ☐

† What method of decontamination has been used? Please provide details

Cleaning _____ _____

Disinfection _____ _____

Sterilization _____ _____

‡ Please explain why the item has not been decontaminated?

_____ _____ _____

_____ _____ _____

Contaminated items should be returned without prior agreement of the recipient

This item has been prepared to ensure safe handling and transportation:

Name _____ Position _____ __

Signature _____

Date _____ __ Tel _____

Declaration of contamination status MHRA db2006 (05)