Policy 613: Determination of Death in The Field

Revision 5/22/18
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I. Purpose:

A. This policy outlines the process by which field personnel (ALS & BLS) may determine death or obtain a pronouncement of death. Field personnel need not initiate or continue resuscitative efforts when death has been determined, respective to their scope of practice, using the following steps and criteria outlined below. Only physicians and coroners can make a pronouncement of death. This policy applies to both adult and pediatric patients.

B. In all cases where determination of death is considered, it is assumed that the patient has no pulse or respirations.

1. If there is any doubt, initiate CPR and resuscitative efforts.

2. Patients may be treated and transported, if in the judgment of the paramedic, the scene dictates that this would be beneficial for field personnel (scene safety) or other causes not outlined in this policy.

3. If resuscitation efforts continue during transport or are initiated during transport, the paramedic will not request a pronouncement of death. In addition, Base Station contact is expected for any patients or situations that do not specifically meet the following criteria. In those cases where Base Station contact is made, the Base Hospital physician will have final authority as to what course of action shall be taken.

C. Patients who present with the document “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” which includes the patient’s name, signature and date, base contact will be made to determine course of action unless a valid DNR, POLST, and/or Durable Power of Attorney is present on scene.

1. A patient may at any time withdraw or rescind aid-in dying regardless of the patient’s mental state. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to consult with their base hospital in these situations. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug.

2. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided, and Base Hospital contact will be made for further direction. Obtain a copy of the final attestation and attach it with the EMS Report Form. See Policy 614, Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Orders/Directives and The End of Life Options Act

D. If the patient clearly meets one or more of the following criteria the patient may be determined dead with no Base Station contact necessary.

1. In all cases where death has been determined, notify the Coroner's Office or other responsible law enforcement agency.
2. A representative from Fire/EMS must remain on scene until a representative from either law enforcement or the Coroner's Office arrives on scene.

II. Definitions:

A. Absence of life signs is the physical examination of the patient including:

1. Palpating pulse for minimum of sixty (60) seconds. Assessing absence of respirations for minimum of sixty (60) seconds.
2. Absence of $EtCO_2$ waveform or readings greater than 10
3. Asystole determined using cardiac monitor, attaching leads, and documenting asystole in two (2) leads for a minimum of sixty (60) seconds.
4. Rigor Mortis- The stiffness seen in corpses. Rigor mortis begins with the muscles of mastication and progresses from the head down the body affecting the legs and feet last. Generally manifested in 1 to 6 hours and a maximum of 6 to 24 hours.
5. Livor Mortis (Lividity) - Cutaneous dark spots on dependent portions of a corpse. Generally manifested within 1/2 to 2 hours. Reaches maximum presentation in 8 to12 hours.

B. DNR – Do Not Resuscitate

C. POLST – Physician Orders for Life-Sustaining Treatment

D. DNR Medallion - Bracelet or Necklace worn by the patient. See Policy 614, Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Orders/Directives and The End of Life Options Act

III. To determine a patient dead at least one or more of the following criteria below must be applicable.

A. Causes for Determination of Death (BLS/ALS)

1. Decapitation.
2. Incineration.
3. Rigor Mortis.
4. Livor Mortis (Lividity).
5. Decomposition.
6. Massive crushing and/or penetrating injury with total separation of the heart, lung or brain.

7. Absence of life signs or severely compromised vital signs when there are multiple victims, and resuscitation would hinder care of more viable patients.

8. In the context of cardiac arrest, the presence of a Valid DNR, POLST, DNR Medallion and/or situation where Durable Power of Attorney is applicable. Refer to Policy 614 Guidelines for EMS Personnel Regarding Do Not Resuscitate (DNR) Orders/Directives and The End of Life Options Act

9. Submersion greater than or equal to twenty-four (24) hours: Physical examination of body with accurate and reliable history of submersion time.

B. Causes for Determination of Death (ALS Only)

1. Adult and Pediatric Medical Cardiac Arrest:

a) Patient remains in cardiac arrest despite application of correct cardiac arrest algorithm.

b) In this case, responders must complete all interventions and medication dosing as prescribed in the appropriate algorithm and verify that the patient has been pulseless and apneic for at least 20 contiguous minutes in the presence of EMS responders. In cases of PEA, cardiac arrest is confirmed by absence of $EtCO_2$ readings of 10 mmHg or greater for 20 minutes.

c) In these instances, ALS personnel may determine the patient dead based on the patient's lack of response to all BLS and ALS interventions. The exceptions to this rule are those patients deemed to be severely hypothermic and patients in the second or third trimester of pregnancy. These patients should be promptly treated and transported to the closest available facility.

d) An $EtCO_2$level of 10 mmHg or less measured 20 contiguous minutes after the initiation of advanced cardiac life support accurately predicts death in patients with cardiac arrest associated with electrical activity but no pulse. In patients for whom this is the case, resuscitation may be discontinued.

2. Adult and Pediatric Traumatic Arrest:

a) Traumatic injuries (blunt or penetrating) with absence of life signs.

b) If patient is found to have either asystole or PEA with a rate less than 40 bpm on initial exam, no workup is necessary. The patient may be determined dead. If the patient is found in PEA with a rate greater than 40 bpm, base station contact should be made to discuss a field pronouncement. In the interim, resuscitation should be commenced.

c) If the patient is found to be in ventricular fibrillation or pulseless ventricular tachycardia, resuscitation should be commenced as outlined in Section IIIA

above. In this instance, determination of death may then be made based on the patient's lack of response to the BLS and ALS interventions. Traumatic arrest patients in the second or third trimester of pregnancy should be transported immediately with a full resuscitation effort to potentially save the fetus.

IV. Causes for Pronouncement of Death (Base Station Physician or Coroner/Deputy Coroner Only)

A. Instances where a clear determination of death cannot be made.

B. Instances where the situation surrounding the patient's death are less clear, or when scene conditions, patient history, by-standing family or other circumstances make it prudent for paramedics and EMTs to seek the counsel and direction of the Base Station.

V. Disposition of the Patient Who Has Been Determined/Pronounced Dead

A. Cases Where Death Is Expected

1. In cases where a patient has a terminal illness and a valid DNR/DNR Medallion/DPAHCD, EMS responders may leave the patient with family and/or caregivers. If no responsible party is present on scene, one responder agency should remain on scene until a responsible party – family/caregivers, law enforcement, coroner or coroner's deputy, or mortuary personnel, etc. – arrives at the scene.

B. Cases Where Death Is Unexpected

1. In cases where death of the patient is unexpected, one EMS responder agency must stay with the patient until a responsible official agency – law enforcement or coroner/deputy coroner – arrives to take over custody of the body. Steps should be taken to preserve all aspects of the patient's immediate personal effects, and any other surrounding material that may be needed by the coroner or law enforcement personnel.

C. Disposition of the Patient's Body

1. In cases where the patient has been determined/pronounced dead in a public setting, responders should use all means to protect the patient's privacy and dignity. The patient should be placed in the ambulance when possible, or appropriately covered while awaiting law enforcement and the coroner's unit.

DETERMINATION/PRONOUNCEMENT OF DEATH CHECKLIST

Incident Date:	Primary Paramedic/EMT
Incident Number:	FFD/Secondary Paramedic/EMT
Report Author:	

Mark the criteria that qualifies this patient for determination/pronouncement of death.

BLS	comments
Decapitation	☐
Incineration	☐
Rigor Mortis	☐
Lividity	☐
Pulseless + absence of vital organs	☐
MCI Triage Decision	☐
Valid DNR, POLST, DPAHCD	☐
Submersion <=24 hours + pulseless	☐
Decomposition	☐
ALS	
Asystole, or PEA with rate <40 complexes per minute (Trauma Only)	☐
Persistent cardiac arrest and $EtCO_2$ < 10mmHg after >20 min. resuscitation	☐
Pulselessness confirmed for a minimum of 60 seconds	☐
Apnea confirmed for a minimum of 60 seconds	☐
Absence of heart sounds confirmed for minimum of 60 seconds	☐
$EtCO_2$ at zero/unreadable for minimum of 60 seconds	☐
Patient observed for 10 minutes, with recheck of above criteria at 10-minute mark with no changes	☐
Hard copy of terminal rhythm ran for 60 seconds.	☐
Other criteria met:	☐
Base Station contacted	☐
Comments	

Primary Paramedic Signature Date