



HPFT

Staff Responsible for Care After Death Policy

(Last Offices) for the Suspected/Known Infectious Service User

HPFT Policy

Version	5
Executive Lead	Exec Director Quality & Medical Leadership
Lead Author	Consultant Nurse Infection Prevention and Control
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Approved By	Infection Prevention and Control Committee (Chairs Action)
Ratified Date	8 th October 2018
Ratified By	Infection Prevention and Control Committee (Chairs Action)
Issue Date	8 th October 2018
Expiry Date	8 th October 2021
Target Audience	These guidelines are applicable to all Hertfordshire Partnership University NHS Foundation Trust direct care staff

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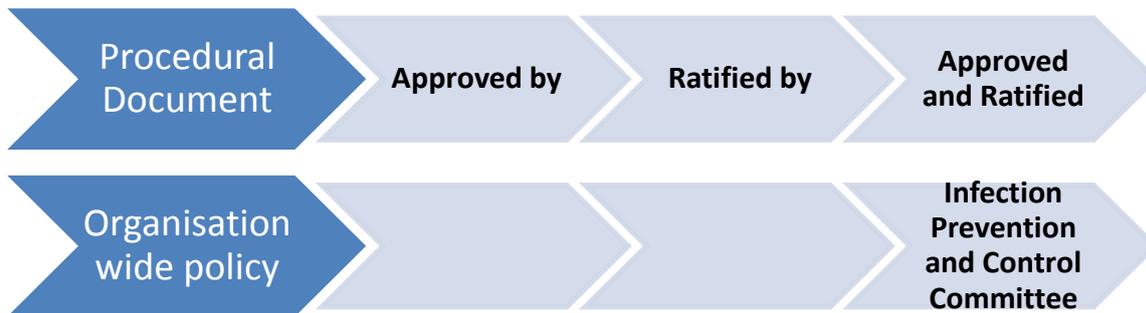
Title of document	Staff Responsible for Care After Death Policy		
Document Type	Policy		
Ratifying Committee	Infection Prevention and Control Committee		
Version	Issue Date	Review Date	Lead Author
5	08/10/2018	08/10/2021	Consultant Nurse Infection Prevention and Control
Staff need to know about this policy because (complete in 50 words)	<p>Staff carrying out care after death practices may be compromised as the deceased person may pose an infection hazard to people who handle them. It is essential that certain infection prevention and control and health and safety requirements are implemented.</p> <p>This policy will identify how the deceased body must be prepared in a way as to prevent the transmission of infection to Hertfordshire Partnership NHS Foundation Trust (the Trust) staff and to the receiving mortuary staff or funeral directors.</p>		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	<ol style="list-style-type: none"> 1. The body of a deceased person who has been diagnosed with an infectious disease may remain infectious after they have died. Therefore, after death, it is essential that standard infection control precautions are implemented when handling these individuals. 2. Staff can prevent the risk of transmission of infection by breaking the chain of infection. 3. The guidance within this policy identifies the Trust requirements for managing the risks associated with infection prevention and control as required by The Health and Social Care Act 2008 (revised Dec 2015)- Code of Practice on the prevention and control of infections and related guidance. 		
Summary of significant changes from previous version are:	<p>Policy format change</p> <p>Changes to the training needs for staff</p>		

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PART 1 – Preliminary Issues:

1. Flow chart



2. Introduction

Traditionally, the term “last offices” relates to the physical care given to a body after death. It is a process that demonstrates respect for the deceased. The procedure focuses on respecting religious and cultural beliefs as well as health and safety and legal requirements (Dougherty and Lister, 2004).

However, the term “care after death” is now more commonly used to reflect our multi-cultural society and the physical preparation of the body itself is now commonly referred to as “personal care after death”.

Care after death includes:

- ensuring that all legal obligations are met when caring for the deceased person and their family/carers
- preparing the deceased body for transfer to the mortuary or the Funeral Director’s premises
- offering family/carers present the opportunity to participate in the process and supporting them to do so
- ensuring that the privacy and dignity of the deceased person is maintained
- ensuring that the health and safety of everyone who comes into contact with the deceased body is protected
- honouring peoples wishes for organ and tissue donation
- returning the deceased person’s personal possessions to their family/carers.

Staff carrying out these procedures are required to implement sensitive and skilled communication, addressing the needs of family /carers and respecting the integrity of the person who has died. It can be a difficult time for those who have been bereaved and can also be emotionally challenging for any staff involved in these practices (National End of Life Care Programme and National Nurse Consultant Group (Palliative Care). Staff should also provide the family/carers of the deceased with advice and information on their own wellbeing and how to deal with their bereavement including accessing appropriate services.

As identified in ‘One Chance to Get it Right’ (June 2014, Leadership Alliance for the Care of Dying People, Publications Gateway Ref 01509),to reduce the levels of

distress that these situations cause, the Trust encourages 'Staff, to find out from the dying person, their family and those important to them, the details of any cultural or religious-specific requirements, including what constitutes respectful treatment of the body after death.'

However, these practices may be compromised as in some cases, the deceased person may pose an infection hazard to people who handle them and it is essential that certain infection prevention and control and health and safety requirements are implemented.

Following death, the deceased body must be prepared in a way as to prevent the transmission of infection to Trust staff and to the receiving mortuary staff or funeral directors. It is important to note that any infection risk present prior to death will also be present after death (Higgins, 2008).

The guidance within this policy identifies the Trust requirements for managing the risks associated with infection prevention and control as required by 'The Health and Social Care Act' 2008 (revised Dec 2015), Code of Practice on the prevention and control of infections and related guidance

For general care after death procedures, please refer to the Trust's Following the Death of a Service User and the Support for the Bereaved -Policy, Guidance and Procedure.

3. Purpose

This guidance outlines the precautions required to minimise the risk to Trust staff, relatives of the deceased person and funeral directors when the deceased person may pose an infection hazard.

4. Definitions

Body fluids	Any substance/fluid from the body
Last Offices	Following death, this is the traditional term that was used when nursing staff carried out physical care on the individual
Care after death	Reflects the differing nursing tasks involved after a service user has died, including on-going support of the family and carers.
Personal care after death	The physical preparation of the deceased body
Infection	Where the deceased body is invaded by a harmful organism (pathogen) which causes disease or illness

- Advising on the appropriate personal protective equipment required to ensure safe and effective practices relating to the care after death of individuals who have a suspected/confirmed infection.

5.7 Heads of Nursing

The Heads of Nursing need to ensure the implementation of infection prevention and control policies, guidance and initiatives such as the Health and Social Care Act, 2008 (revised 2015) – Code of Practice for the Prevention and Control of Infections and related guidance, within their service areas.

The Heads of Nursing are also responsible for overseeing the implementation of this guidance within their service areas.

5.8 Matrons

The Matrons are responsible for ensuring that their staff are compliant with this policy.

5.8 Team Leaders

Team Leaders are responsible for ensuring all staff undertake induction training and updates thereafter as identified in the Trust's Training Needs Analysis. Team Leaders are also required to ensure that personal protective equipment (PPE) and products are appropriately provided and that staff wear the PPE correctly.

5.9 Infection Prevention and Control (IPC) Link Practitioners

IPC Link practitioners are the service areas' lead for IPC and are responsible for ensuring that the monitoring, standards and auditing of IPC is maintained in accordance with Trust and National Guidelines.

5.10 All Employees

All staff are required to promote infection control and encourage colleagues and other Trust users to use good practice.

All staff who carry out the care after death procedure should:

- Read, understand and comply with the information identified in this guidance
- Assist in raising the awareness of other healthcare workers of the importance of infection control and adherence to the Trust's policies
- Attend training in relation to infection prevention and control

Full details of the roles and responsibilities of staff relating to IPC can be found in the Trust's Infection Prevention and Control Policy

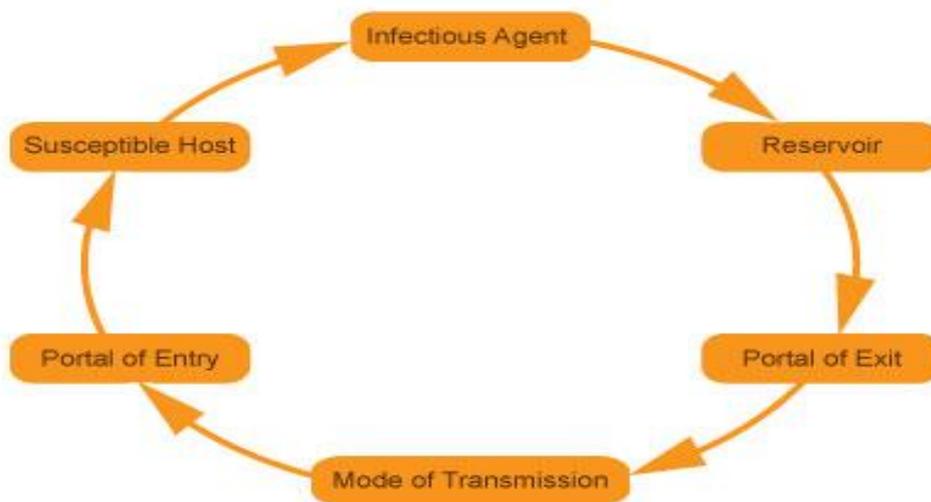
6. Identifying the Risks

Infectious micro-organisms/biological agents include bacteria, viruses, fungi and internal parasites (such as tapeworms) that create a hazard to human health.

The process of infection can be represented as a chain - breaking a link in the chain at any point will control the risk of infection. When the hazard has been identified, the risks associated with transmission of the infection will need to be implemented.

6.1 The Chain of Infection

The diagram below represents how a service user can acquire an infection from somebody else. The links of the chain show how organisms are transferred and where staff can put prevention strategies in place to break the chain and stop infection spreading.



6.1.1 Infectious Agent

Some micro-organisms cause illness and some do not. Many micro-organisms live in or on some parts of the body (skin, mouth, intestinal tract) and are known as the body's skin flora. Some of these may cause illness if they find their way into other areas of the body. For example, when micro-organisms that are normally found in the bowel enter the bladder – this may then cause infection in the bladder.

Normal skin flora is known as “resident” which means it is there all of the time. It rarely causes infection apart from possible introduction during invasive procedures, for example insertion of an intravenous line or urinary catheter. Resident skin flora lives naturally on the skin and is difficult to remove by normal hand hygiene techniques, although the numbers of micro-organisms can be reduced by this.

Many other micro-organisms are acquired or transmitted on the skin from other staff or residents or from the environment. These micro-organisms are

known as “transient”. These do not live permanently on the skin and are readily removed or destroyed by thorough and frequent hand hygiene.

Those micro-organisms that cause infections are known as pathogens. They are classified as:

Bacteria	These are classified into different groups and can be pathogenic. They are susceptible to a greater or lesser extent to antibiotics e.g. MRSA
Virus	A virus is much smaller than bacteria and can survive out of the body for a time. Viruses are not susceptible to antibiotics although anti-viral drugs are available.
Pathogenic Fungi	Can either be moulds or yeast. Examples include ringworm and thrush.
Protozoa	Microscopic free living organisms e.g. <i>Giardia lamblia</i> which causes diarrhoea Parasites. Some are pathogenic and cause infection and are spread from person to person e.g. scabies.
Prions	Are infectious protein particles, e.g. the prion causing New Variant Creutzfeldt-Jakob Disease.

6.1.2 The Reservoirs

The reservoirs of micro-organisms may be people, the environment or the equipment. The human body is the biggest reservoir for potentially harmful micro-organisms and the most common source of infection.

Contaminated food may also act as a reservoir of infection. For example, if food that contains Salmonella is not thoroughly cooked, individuals who eat it can become infected.

The environment can be contaminated by micro-organisms shed by people with an infection. This can then become a reservoir for spread to others.

Poorly maintained or incorrectly decontaminated equipment can also act as a reservoir of micro-organisms. For example, inadequately maintained suction machines may cause respiratory infections.

6.1.3 Point of Entry and Exit

Every microorganism requires an entry point into the human body and an exit point to get out. For example, Salmonella bacteria need to enter the body through the mouth and are excreted through faeces.

6.1.4 Method of Spread or Mode of Transmission

All micro-organisms need a mode of transmission. There are several methods of spread which include:-

- **Direct contact** –organisms can be transmitted directly to susceptible people via contaminated equipment or by the hands of healthcare workers. It is essential that hands are decontaminated before and after every episode of direct patient care. Equipment must be kept clean and dry and must be correctly decontaminated between each use
- **Airborne** – micro-organisms can be transmitted in dust or skin scales that are carried by the air during procedures such as bed making or via respiratory droplets. The chances of acquiring infection from inhaling organisms are low. More commonly, respiratory secretions such as those from influenza or colds are acquired by contact with secretions deposited onto hands/handkerchiefs and surfaces
- **Faecal-oral transmission-** Gastro intestinal infection may result from ingestion of food and water contaminated with micro-organisms or from cross infection from individuals already infected e.g. aerosols created during diarrhoea/vomiting episodes may result in transmitting gastro-intestinal infections
- **Blood borne** – blood or blood stained material is potentially hazardous and infection is transmitted via inoculation injuries for example needle stick injury, bite, scratch. Transmission is also possible via existing breaks in the skin, during sexual activity or across the placenta from mother to baby
- **Vector borne** (insects and parasites) – diseases can be transmitted via biting insects. This is not a huge problem in the UK; however insects such as cockroaches can carry harmful micro- organisms on their bodies and in their digestive tracts. This may infect the healthcare environment, including food and sterile supplies. Therefore storage of supplies in clean, well ventilated areas is essential.

6.1.5 Susceptible Host

Once the micro-organisms have reached their “target” the person must be at risk of infection. Infection is caused by organisms that invade the host’s immune system. Susceptibility to infection varies from person to person. Factors that affect a person’s susceptibility to infection include:

- Age (the very young and very old are more susceptible)

- Immune status
- Physical well being
- Psychological well being
- Hygiene
- Underlying or chronic diseases or medical conditions (e.g. diabetes, chronic chest and heart problems or cancer)
- Other existing infections
- Medical interventions (e.g. indwelling medical device such as a urinary catheter)
- Medical therapies (e.g. cancer chemotherapy)

Please refer to the Trust's Policy A-Z of Infections, for further information regarding the chain of infection.

6.1.6 Sources

There are four main sources of infection:

- blood and other body fluids (for example saliva, pleural fluids)
- waste products, such as faeces and urine
- aerosols of infectious material
- skin, direct contact.

6.1.7 Transmission

To transmit micro-organism from one place to another, they have to get from the source into the host by some means. Most micro-organisms usually have a particular route of entry, but in some cases infection can occur by more than one route.

Infection can occur via:

- putting contaminated hands and fingers into the mouth, nose or eyes
- breathing in small infectious droplets (aerosols) from the air
- splashes of blood and other body fluids into the eye and other mucous membranes, such as the nose and the mouth
- broken skin if it comes into direct contact with the micro-organism a skin-penetrating injury, for example via a contaminated needle or other sharp.

7 Infection Prevention and Control Practices

Prevention

It is important to note that the body of a deceased person who has been diagnosed with an infectious disease may remain infectious after they have died. Therefore, after death, it is essential that standard infection control precautions are implemented when handling these individuals. (Please refer to the Trust Policy – Standard Infection Control Precautions for further information)

Body fluids may leak after death and specific precautions, including the use of body bags, may be required for specific infectious diseases. (Please refer to **appendix 1** for further guidance.)

It is vital that good communication between staff and the service user's family/carer will be required as some of these practices, such as the use of danger of infection labels (please refer to **appendix 2**), may cause offence or concern.

In addition to the routine procedures to minimise the risk, the following practices must be followed:-

- Staff should be immunised against any specific infections
- The laying out procedure must be carried out by the health care worker or family/carers (under supervision) wearing disposable gloves and aprons
- There should be minimal handling of the body
- Movement of the deceased person, particularly the chest area, should be minimised. This will reduce the risk of airborne infection
- All leaking wounds or unhealed surgical wounds should be sealed with a dry dressing and secure with an occlusive dressing. Waterproof, strongly adhesive tape should be avoided as this can be difficult to remove at the Funeral Directors and can leave a permanent mark
- Any stiches or clips should be kept intact
- Leaking orifices may need to be packed
- Nasogastric tubes should be suctioned and a spigot applied
- Stomas should be covered with a clean bag
- Unless it has been referred to the Coroner, all intravenous infusion devices, drains, tubes and catheters, etc. should be removed and discarded as clinical waste
- Sharps must be disposed of in a sharps box, at the point of use
- The deceased person should be placed in a disposable shroud or person's own clothes (depending on the wishes of the relatives) and then wrapped in a sheet before being placed in a body bag, which must be carefully secured
- Body bags are available from ELFS (non stock item)

- 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 (can be ordered from ELFS – non stock item)
- Once the body is sealed in the body bag, protective clothing will no longer be necessary for those who handle the body bag
- Disposable gloves and aprons are to be discarded as clinical waste and hands should be washed and dried thoroughly
- Family/carers who wish to view the deceased person should do so, soon after death, if possible

However, there are provisions under the Public Health (Control of Diseases) Act 1984, for people to be prevented from contact with the body of a person dying with a notifiable infectious disease

- Family/carers should be informed of the infection risk and the infection control precautions to take. Confidentiality of the service user still applies after death
- Mortuary staff and Funeral Directors must always be informed of the infectious nature of the body when a body presents a serious infection risk
- Body bags should also be used for leaking bodies, mutilated, decomposing and forensic cases
- Body bags must also be used for individuals who die with an imported highly suspected infectious disease of unknown diagnosis i.e. admitted directly from abroad.

8 Training and Awareness

The competencies required for effective infection prevention and control must be obtained and maintained by implementing the relevant infection prevention and control training and following Trust infection prevention and control procedures.

Team Leaders must ensure that new employed staff are made aware of the Trust's infection prevention and control procedures during induction.

Course	For	Renewal Period	Delivery Mode
Infection Prevention and Control Training	Level 1 training - All admin staff, contractors, non-clinical staff Level 2 training – All staff carrying out clinical duties	Every 2 years	E-learning

9 Process for monitoring compliance with this document

What	How	Who	When	Where	Who
Standard Infection Prevention and Control Precautions	Audit Implementation	Modern Matron/Team Leader/ Link Practitioner	1-3 monthly audits of Hand Hygiene and Essential Steps	Infection Prevention and Control Committee	Infection Prevention and Control Committee

10 Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Service user, carer and/or staff access needs (including disability)	The implementation of this policy will not discriminate against any service users, carer and/or staff access needs
Involvement	The implementation of this policy will not discriminate against any involvement of service users, carer and/or staff.
Relationships & Sexual Orientation	The implementation of this policy will not discriminate against any relationships to sexual orientation
Culture & Ethnicity	The implementation of this policy will not discriminate against any culture and ethnicity.
Spirituality	The implementation of this policy will not discriminate against any spirituality
Age	The implementation of this policy will not discriminate against any age
Gender & Gender Reassignment	The implementation of this policy will not discriminate against any gender or gender reassignment
Advancing equality of opportunity	The implementation of this policy will ensure that all service users, carer and staff are treated equally and will be given equal opportunities.

11 Promoting and Considering Individual Wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;

- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary

Part 3 – Document Control & Standards Information

12. Version Control

Version	Date of Issue	Author	Status	Comment
V1	December 2007	Lead Infection Control Nurse	Superseded	New Policy
V2	December 2009	Lead Infection Control Nurse	Superseded	V1 reviewed with minor Changes. Agreed Lead Nurse Strategy group 22.01.09 and ICC 14.01.09
V3	April 2011	Lead Infection Control Nurse	Superseded	V2 reviewed with minor changes
V4	27 th April 2015	Lead Infection Control Nurse	Superseded	Full review
V5	8 th October 2018	Consultant Nurse Infection Prevention and Control	Current	Full review

13.Relevant Standards

The Health and Social Care Act 2008, revised 2015, Code of Practice on the prevention and control of infections and related guidance

14. Associated Documents

This policy should be used in conjunction with the following Hertfordshire Partnership NHS Foundation Trust Infection Control policies all of which are available on the HPFT staff website:

- Hand hygiene
- A-Z of infections
- Standard infection control precautions
- Decontamination

- Handling and Disposal of Waste
- Management of Infection Prevention & Control Policy
- Sharps Safety
- Following The Death Of A Service User And The Support Of The Bereaved

15. Supporting References

Ashford and St.Peter’s Hospitals NHS Trust (2006), Last Offices for the Infectious Patient.

Bakhshi, SS (2001). The Code of practice or funeral workers Managing Infection Risk and Body Bagging, Communicable Disease and Public Health, Vol 4, No 4, December 2001

Controlling the risks of infection at work from human remains, HSE, 06/05

Higgins, D. (2008) Carrying out last offices Part 1 - Preparing for the Procedure. *Nursing Times*; 104: 37, 20-21.

Liverpool Care Pathway. *One Chance to Get it Right* (June 2014, Leadership Alliance for the Care of Dying People, Publications Gateway Ref 01509) - National End of Life Care Programme and National Nurse Consultant Group (Palliative Care).2014

Philpott-Howard, J. and Casewell, M (1994) Hospital Infection Control Policies and Practical Procedures 1994, WB Saunders Company Ltd, Page 181.

The infection hazards of human cadavers: guidelines on precautions to be taken with cadavers of those who have died with a known or suspected infection, Health Protection Agency North West, 2004

16. Consultation

The Consultation section of the Policy Management System advises on the types of people to invite to express their views and give constructive suggestions to improve the draft policy being worked on.

In the case of the Procedural Document Management System, the following have been consulted so far.

Job Title of person consulted
Executive Director Quality & Safety
Infection Prevention and Control Committee
Spiritual Care Manager
Head of Safeguarding
Customer Inclusion & Engagement Team Manager
Deputy Director of Nursing and Quality
Matrons
Heads of Nursing

Appendix 1 – Key Infections

Appendix 1 – Key Infections

Infection	Causative agent	Is a body bag needed?	Can the body be viewed?	Can hygienic preparation be carried out?	Can embalming be carried out?
Intestinal infections: Transmitted by hand-to-mouth contact with faecal material or faecally contaminated objects					
Dysentery (bacillary)	Bacterium - <i>Shigella dysenteriae</i>	Advised	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	No	Yes	Yes	Yes
Typhoid/ paratyphoid fever	Bacterium – <i>Salmonella typhi/paratyphi</i>	Advised	Yes	Yes	Yes
Blood-borne infections: Transmitted by contact with blood (and other body fluids which may be contaminated with blood) via a skin-penetrating injury or via broken skin. Through splashes of blood (and other body fluids which may be contaminated with blood) to eyes, nose and mouth					
HIV	Human immunodeficiency virus	Yes	Yes	Yes	No
Hepatitis B and C	Hepatitis B and C viruses	Yes	Yes	Yes	No
Respiratory infections: Transmitted by breathing in infectious respiratory discharges					
Tuberculosis	Bacterium - <i>Mycobacterium tuberculosis</i>	Advised	Yes	Yes	Yes
Meningococcal meningitis (with or without septicemia)	Bacterium – <i>Neisseria meningitidis</i>	No	Yes	Yes	Yes
Non-meningococcal meningitis	Various bacteria including <i>Haemophilus influenzae</i> and also viruses	No	Yes	Yes	Yes
Diphtheria <i>Corynebacterium diphtheriae</i>	Bacterium –	Advised	Yes	Yes	Yes
Contact: Transmitted by direct skin contact or contact with contaminated objects					
Invasive Streptococcal infection (Group A)	Bacterium – <i>Streptococcus pyogenes</i>	Yes	Yes	No	No
MRSA <i>Staphylococcus aureus</i>	Bacterium – methicillin resistant	No	Yes	Yes	Yes
Other infections					
Viral haemorrhagic fevers (transmitted by contact with blood)	Various viruses, e.g. Lassa fever virus, Ebola virus	Yes	No	No	No
Transmissible spongiform encephalopathies (transmitted by puncture wounds, 'sharps' injuries or contamination of broken skin, by splashing of the mucous membranes)	Various prions, e.g. Creutzfeldt Jacob disease/ variant CJD	Yes	Yes	Yes	No

Agent/disease	Means of transmission	Survivability	Notes for guidance
<i>Bacillus anthracis</i> / anthrax	Breathing in aerosols, direct contact with broken skin, and by hand to mouth contact	Probably indefinitely in the spore form	Anthrax spores may be found in the exhumed body, and also in items such as pillows and linings stuffed with horsehair. Anything stuffed with animal hair should be bagged and disposed of as clinical waste
Variola major virus/ smallpox	Inhalation and contact	Can survive for long periods of time in dry scabs (13 years has been documented). However, in normal environmental conditions, the virus is very unlikely to survive for more than 48 hours	The virus that caused smallpox has been eliminated from the world population and the last cases that occurred in this country were mainly in the 1930s, however there were sporadic cases after that date but none after the 1970s. Intact virus was found in a body exhumed at Spitalfields in 1985, this body was more than 100 years old. But the virus could not be grown, so was not considered to be infective
<i>Clostridium tetani</i> / tetanus	Skin-penetrating injury	Commonly found in soil	Employees should be immunised against tetanus. You should ensure that this remains current
<i>Leptospira icterohaemorrhagiae</i> / Weil's disease	Contact with broken skin	Found in association with rats	Agent is excreted in infected rat urine, so soil/water present on site may be contaminated

Part 2: Additional infection information for exhumation

The infectious micro-organisms listed above may present a risk to those carrying out exhumation of the recently deceased, however, the majority of these micro-organisms will no longer be viable after a period of about six months. However, if the deceased has died from a transmissible spongiform encephalopathy such as Creutzfeldt-Jakob Disease (CJD) this may be present in the body for a substantial period of time.

None of the organisms that caused mass death in the past, for example plague, cholera, typhoid and tuberculosis are likely to survive in buried human remains when exhumed from an old internment. There is however a possibility that those

organisms that caused death from anthrax or from smallpox may have survived and these need to be considered in any assessment. Further information on these agents, and others that may be present in the environment, is given in the table below.

	<i>we are...</i>	<i>you feel...</i>
Our Values	Welcoming	✔ Valued as an individual
	Kind	✔ Cared for
	Positive	✔ Supported and included
	Respectful	✔ Listened to and heard
	Professional	✔ Safe and confident

Our  values
 Welcoming Kind Positive Respectful Professional