Public Health England

Protecting and improving the nation's health

# Ebola: Information for the Funeral Industry, Coroners' Offices and Pathology Departments

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**The aim of this guidance is to address Ebola-related queries PHE have received from people working in the funeral industry and coroners' offices, and to support PHE health protection teams in addressing these queries.**

The Advisory Committee on Dangerous Pathogens, Health and Safety Executive, National Association of Funeral Directors, Federation of Burial and Cremation Authorities, and the Royal College of Pathologists have been consulted on this document.

Ebola virus disease (EVD), a viral haemorrhagic fever (VHF), is a rare but severe infection caused by Ebola virus. Since March 2014, there has been a large outbreak of Ebola virus in West Africa, with widespread and intense transmission in Guinea, Liberia and Sierra Leone. This is the largest ever known outbreak of this disease prompting the World Health Organization (WHO) to declare a Public Health Emergency of International Concern in August 2014. Cases have also occurred in Mali, Nigeria, Senegal, Spain, the UK and the US.

While a fever in persons who have travelled to Ebola transmission areas is more likely to be caused by a common infection, such as malaria or typhoid fever, healthcare professionals in the UK have been advised to remain vigilant for those who have visited areas affected by this outbreak and subsequently become unwell; mortuary staff should also remain vigilant. The risk of a patient with known or suspected EVD being encountered in the mortuary is very low, but not zero.

It is also possible that funeral directors in the UK may receive requests from companies or organisations regarding the repatriation of the remains of UK citizens from Ebola-affected countries for burial. The cross-border transportation of Ebola-infected bodies is not recommended; see Repatriation of human remains from Ebola-affected countries for details of who to contact for advice should this question arise.

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## Ebola transmission

Ebola virus is transmitted among humans through close and direct physical contact with infected body fluids. This means that the body fluids from an infected person (alive or dead) have touched someone's eyes, nose or mouth, or an open cut, wound or abrasion (eg through splashes of blood or other body fluids during post-mortem care). Infection can also occur if broken skin or mucous membranes of a healthy person come into contact with environments that have become contaminated with an Ebola patient's infectious fluids such as soiled clothing, bed linen, used needles, or instruments used during post-mortem care. Ebola is not spread by the airborne route.

People infected with Ebola can only spread the virus to other people once they have developed symptoms. In the early symptomatic phase, virus is present in the blood; however the level of virus in body fluids such as saliva is very low and unlikely to pose a transmission risk. In the late symptomatic phase, all body fluids (such as blood, urine, faeces, vomit, saliva and semen) should be considered infectious, with blood, faeces and vomit being the most infectious. The skin is almost certainly highly contaminated in late stage disease because of the impossibility of maintaining good hygiene with diarrhoea, vomiting, incontinence etc. The bodies of deceased Ebola-infected persons are highly infectious[1].

Ebola virus is not spread through routine, social contact (such as shaking hands) with asymptomatic individuals.

## National guidance on handling the remains of Ebola-infected people and their possessions

This PHE guidance is intended to supplement and/or direct colleagues to existing national guidance addressing the safe management of human remains of persons with Ebola and other VHF:

- The Advisory Committee on Dangerous Pathogens (ACDP) guidance on Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence (November 2014)[2] is the principal source of guidance on handling suspected Ebola cases after death Appendix 12 focuses on after-death care

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[1] Dowell SF, Mukunu R, Ksiazek TG, Khan AS, Rollin PE, Peters CJ. Transmission of Ebola hemorrhagic fever: a study of risk factors in family members, Kikwit, Democratic Republic of the Congo, 1995. Commission de Luttecontre les Epidemies a Kikwit. The Journal of Infectious Diseases. 1999;179 Suppl 1:S87-91

[2] Advisory Committee on Dangerous Pathogens. Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence: Department of Health, Health and Safety Executive; 2014 [updated November]. Available from: https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

- Appendix 5 of the Royal College of Pathologists guidance on Autopsy in patients with confirmed or suspected Ebola virus disease (September 2014)[3] contains detailed advice regarding the handling of bodies of patients known or suspected of being infected with Ebola or other VHFs. It also covers detailed advice on returning possessions of the deceased to relatives and other interested parties; this advice should be consulted before releasing a body to a funeral director or returning any items that were in the possession of the deceased to any party. Funeral directors dealing with Ebola-infected bodies or other VHF cases are also urged to be familiar with this guidance
- the Health and Safety Executive Controlling the risks of infection at work from human remains

**Key messages**

- the bodies of deceased Ebola-infected persons are **highly infectious.** This should be reflected in the **infection control notification sheet**; it is the responsibility of the Registered Medical Practitioner certifying death to complete this in readiness for the funeral directors, and to alert them to the risk of infection
- **embalming** or hygienic preparation of bodies of confirmed Ebola cases presents an unacceptably high risk and should not be undertaken
- a **post-mortem** examination on a person known to have died of Ebola exposes staff to unwarranted risk and should not be performed
- remains should be **cremated**, but if not possible due to an implanted device and/or religious reasons, buried promptly; burial should be via a double body bag within an appropriately leak-proof robust coffin. Once closed, the body bags and coffin should not be opened
- **religious/ritual preparation** of the bodies of deceased Ebola-infected persons by washing, dressing, viewing, touching or kissing is prohibited
- the only contact with the infected human remains should be in the period following death, to place the body in appropriate bags and coffin. Only personnel trained in handling infected human remains, and wearing personal protective equipment (PPE) as outlined in the ACDP guidance, should touch or move any Ebola-infected remains
    - no PPE is needed when handling cremated remains in a sealed urn or remains double body bagged in a leak-proof robust coffin[4]. Full PPE should be worn for double body bagged remains not in leak-proof robust coffin
- under the International Health Regulations (IHR), the **cross-border movement** of human remains of deceased suspect, probable or confirmed Ebola cases should be prohibited unless under well-defined biosecurity conditions (see page 11). Following cremation, ashes may be safely transported

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[3] Osborn M, Lucas S, Burton J. Autopsy in patients with confirmed or suspected Ebola virus disease (Ebola haemorrhagic fever): The Royal College of Pathologists; 2014 [updated September 2014]. Available from: http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/P/PUBS_EbolaAutopsy_Sept14_V2.pdf

[4] A 'robust coffin' is generally understood to be one constructed from solid or reconstituted wood

## Ebola risk from infected human remains

Anyone who directly handles blood or body fluid samples from Ebola patients, or the remains of deceased Ebola patients, should be using personal protective equipment (PPE), as outlined in the ACDP guidance. No PPE is needed when handling cremated remains or remains in a double body bag within a leak-proof robust coffin (ACDP[3]). However, in the event of any leakage, then PPE should be used.

## Death prior to a definitive diagnosis – persons with suspected Ebola

When a person dies prior to a definitive diagnosis (either in hospital or in the community), and Ebola is suspected as the cause of death, a **risk assessment must be performed prior to any handling of such a body** or performing any investigation into the death (see Appendix 2 of the RCPath guidance[3], which is based on the ACDP algorithm).

## Clinical risk assessment

Ebola should be suspected in a sudden death in a person who had recently visited any of the affected areas (as outlined previously) within the 21 days before death
**OR**
had cared for or come into contact with body fluids of, or handled clinical specimens (blood, urine, faeces, tissues, laboratory cultures) from, an individual or laboratory animal known or strongly suspected to have VHF, within the 21 days before death

- the **assessment** of the deceased's **likelihood of Ebola infection** should be a discussion between (if in a **hospital** setting) the pathologist, the local infection specialist (consultant microbiologist, virologist or infectious disease physician – following consultation with the PHE Imported Fever Service/Rare and Imported Pathogens Laboratory (RIPL)), and the local PHE centre/health protection team (HPT) of the location of the deceased (see postcode lookup for local HPT)
- if a person dies unexpectedly in the **community** and is identified as having a risk factor for Ebola, the Registered Medical Practitioner (RMP) who is called to certify death should contact the local PHE HPT to jointly conduct a **risk assessment** as to the deceased's likelihood of Ebola infection in consultation with the PHE Emergency Response Division (ERD)/ECOSA; ERD will liaise with the Imported Fever Service/RIPL for advice if necessary; they can also advise on appropriate transfers etc. This scenario will be managed on a case-by-case basis
- the attending RMP (with the assistance of the local HPT) should liaise with HM Coroner (or the coroner's officer) for the relevant jurisdiction and inform them that this may be a death due to Ebola virus disease. Together, and if necessary with the input of a pathologist appointed by the coroner, the scenario can then be managed on a case-by-case basis
- the bodies of deceased Ebola-infected persons are **highly infectious**; it is the responsibility of the RMP certifying death to complete an **infection control**

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**notification sheet** in readiness for the funeral director(s) (after conducting the clinical risk assessment), and to alert the funeral director(s) to, and provide them with sufficient information of the risk of infection[2]
    - 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
    - see Appendix 2 infection control notification sheet, in the HSE guidance 'Controlling the risks of infection at work from human remains' for further detail
- unless there is a clear reason to suspect Ebola (or other VHF), then no specific VHF precautions are required for sudden deaths in the community

## Funeral directors and risk assessment

- it is not the responsibility of the funeral director to do a clinical risk assessment as to the likelihood of Ebola infection, but it is their responsibility to ensure the guidance in this, and the other related documents mentioned herein, is adhered to when the body is transferred into their care
- it would be usual for a **funeral director** to conduct their own **risk assessment** before removal of the remains of the deceased, as per their own protocols/guidance; for example, by handling every death in the community on the basis that there may be an undiagnosed Hazard Group 3 bloodborne virus (HG3BBV) or Hazard Group 4 (HG4) pathogen present

## Cremation in England and Wales

The ordinary practice for authorising a cremation involves a two stage certification process.

- The first medical certificate (form 4) is completed by the doctor who treated the deceased person during his or her last illness; the second (form 5) is completed by a doctor who did not treat the deceased person and who is completely independent of the first doctor. The normal requirement is that the second doctor has to examine the deceased person, and discuss the cause of death with the first doctor and at least one other person.
- However, form 5 – and its ordinary requirement to examine the deceased person - may not be required if the death occurred in hospital, the deceased was an in-patient there, a post-mortem examination has been carried out or supervised by a registered medical practitioner of at least 5 years' standing (who is not a relative of the deceased, or a relative, partner or colleague in the same practice or clinical team of the medical practitioner giving form Cremation 4) and the medical practitioner giving form Cremation 4 is fully aware of the post-mortem examination.
- Also, an application for cremation may be made if a coroner certifies that no post-mortem examination or inquest is necessary (form 6).

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It is the advice of PHE that should a death due to a VHF occur, then the use of regulation 18, allowing a coroner's authority to stand in place of the confirmatory medical examination (form 5), is appropriate and preferred to ensure the minimum risk in subsequently handling the deceased's body.

All cases of death suspected to be due to a VHF must be referred promptly to the local coroner. PHE staff should always be consulted to ensure that best practice in infection prevention and control is followed. PHE staff are also able to support local coroners in making suitable risk assessments. The chief coroner has directed all senior coroners that they must inform him of any death potentially die to a VHF. The chief coroner has also confirmed to all senior coroners that in such cases post-mortem examination should not be performed, however, where there is no definitive diagnosis in life, some diagnostic tests may be necessary on public health grounds. *See notes below**

## Post-mortem examination or sampling of persons with suspected Ebola

**Post-mortem examination**

- patients who are known or suspected to have Ebola virus disease (EVD) pose a risk to anatomical pathology technicians, pathologists and funeral directors. A post-mortem examination of a person **known** to have died of (or with) EVD exposes staff to unwarranted risk and **should not be performed**[2,3] except in very exceptional circumstances, and then only in a mortuary equipped to handle Hazard Group 4 pathogens[3]
- if there is the possibility that a post-mortem may be required (eg suspected homicide/medico-legal reasons), anatomical pathology technicians should follow the RCPath guidance[3], and obtain advice from the Royal College of Pathologists' representative (contact details in Appendix 3 of RCPath guidance[3]).

- it may be necessary on public health grounds to undertake some diagnostic tests to either confirm or refute the diagnosis of Ebola, or to provide an alternative diagnosis such as malaria[2,3]
- any ante-mortem blood or other samples should be identified, as these may provide an alternative for diagnostic testing for EVD and negate the necessity for further invasive sampling of the body[3]
- if it is determined from discussions that investigations should proceed, the PHE RIPL can advise on the extent, nature and handling of any limited amount of sampling that will suffice such an assessment (contact details for RIPL in Appendix 4 of RCPath guidance[3])
- personnel obtaining samples from the deceased must wear appropriate PPE following the guidance for safe collection and transport of specimens (see ACDP guidance). Where the deceased is in a Trexler isolator (in the high-level isolation unit (HLIU) at the Royal Free Hospital (London), the specimens should be taken before transferring the body to a leak-proof double body bag, as per the ACDP guidance[2]. Where the results of such tests have found the deceased to be negative for Ebola or other VHF, a post-mortem may be required[2]

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* Notes:

The extant legislation is The Cremation (England and Wales) Regulations 2008

Form 5 must be completed, unless the categories in Regulations 16(c)(iii), 17(3), 18 or 24(2) apply, i.e. when a coroner has issued form Cremation 6, there has been an anatomical examination of the body or there has been a consented post-mortem examination as described above (see paragraph 33).

Regulation 18 in particular allows a coroner to issue an authority under form 6 if:

(a) A post-mortem examination has been made under section 19(1) of the 1988 Act and the cause of death of the deceased person has been certified by the coroner under section 19(3) of that Act
(b) An inquest has been opened; or
(c) The death of the deceased person occurred outside the British Islands and no post-mortem examination or inquest is necessary

Guidance on cremation practice can be found at:
https://www.gov.uk/government/collections/cremation-forms-and-guidance.

The Cremation (England and Wales) Regulations 2008 can be found at:
http://www.legislation.gov.uk/uksi/2008/2841/contents/made.

Detailed guidance on PPE, its use, removal and disposal can be found in Appendix 8 of the ACDP guidance.[2]

Detailed guidance on post mortem sampling can be found in Appendix 5 of the RCPath guidance.[3]

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## Disposal of the remains of those suspected to have died from (or with) Ebola

- anyone who must come into contact with the body of the deceased, or the body bag, coffin or other vessel carrying that body, must be made fully aware of the infection risk and infection control measures in place. This includes all funeral staff involved[2,3]
- bodies of those known or suspected to have died from or with Ebola or similar VHF should be **cremated** at the earliest opportunity if possible[2,3]
- if they cannot be cremated – for example, if a pacemaker, implanted defibrillator, implanted radioactive device or 'Fixion' intramedullary nailing system is present – they should be **buried** as soon as is practicable, to avoid the need to remove the device[2,3]. This should be addressed on a case-by-case basis
    - before the funeral goes ahead, consideration should be given as to how the (greater) cost of burial will be covered, if cremation is not possible

## Preparation of the body following death

The nature of Ebola infection and the associated occupational and public health risks mean that contact and exposure to the deceased should be kept to an absolute minimum with all post-mortem procedures adapted where possible to facilitate this:

- the body of the person known or suspected to have died of Ebola should be removed into a **double body bag**, **labelled as high risk of infection**, and then placed in an appropriately **leak-proof robust[4] coffin** (see Appendix 12 of ACDP guidance*)
- of note:
    - where a confirmed Ebola case has died while being cared for in an **isolator** (Trexler isolator, used in HLIUs), the body bag should be one specially designed for use with the isolator
    - CBRN-bags should not be used (some of them have ABEK filters for off-gassing which may not be liquid release proof when saturated)

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*[1] Advisory Committee on Dangerous Pathogens. Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence: Department of Health, Health and Safety Executive; 2014 [updated November]. Available from: https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

| | For cremation (preferred option) | For burial |
|---|---|---|
| **Body bag (if deceased was not cared for in a Trexler isolator)** | • high-performance, non-permeable, leak-proof<br>• non-PVC body bag<br>• with a 'D' opening/U-shaped zipper[1] (rather than a bag with central zipper running from head to foot)<br>• double bagging<br>• layer of absorbent material between the two bags<br>• bag sealed and disinfected with 1000ppm of available chlorine/other appropriate disinfectant | • high-performance, non-permeable, leak-proof<br>• with a 'D' opening/U-shaped zipper[1] (rather than a bag with central zipper running from head to foot)<br>• double bagging<br>• layer of absorbent material between the two bags<br>• bag sealed and disinfected with 1000ppm of available chlorine/other appropriate disinfectant |
| **Coffin** | • robust coffin[2]<br>• lined with high-quality cremfilm[3]<br>• 'double-fill' cremfilm[5]<br>• sealed coffin joints: with a non-PVC sealant (eg bathroom sealant)[6] | • robust coffin[2]<br>• lined with high-quality cremfilm[3] OR zinc-lined[4]<br>• 'double fill' cremfilm[5]<br>• sealed coffin joints |

1. 'D-opening' bag allows for the remains to be loaded with minimal handling
2. generally understood to be one constructed from solid or reconstituted wood
3. Cremfilm: a descriptor of a waterproof polyethylene plastic lining, approved for cremation; lead, zinc or other metal linings are not permitted for cremation
4. A zinc-lined coffin is only a requirement for repatriation of human remains, when the coffin should be zinc-lined, soldered closed and with sealed joints. However, cross-border movement of Ebola-infected remains is not recommended in the current outbreak; a zinc-lined coffin can be used for burial, but many cemeteries will not now accept these coffins because of concerns re environmental impact
5. 'double fill' cremfilm refers to the doubling over of the cremfilm in a coffin so as to provide two layers of polyethylene lining, mitigating against leakage; a heavier single layer equivalent to a double layer could also be used for cremation as long as a complete seal can be obtained
6. Non-PVC sealant: this would improve the leak-proof qualities and not preclude cremation

- once sealed as above, the coffin and body bag should **not be opened**, nor the remains touched or removed from body bags
  - reasonable steps should be taken to ensure the **identity of the deceased** person obtained can be ensured without opening the body bags
- minimum mortuary storage safeguard: double body bag in a separate and identified cold store unit to await prompt cremation or burial

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- if in an exceptional circumstance the coffin or body bag do need to be opened this must only be done by a designated person, wearing full PPE and using all safety measures as outlined elsewhere in this document, after consultation, and with the authority of, the consultant in communicable disease control (CCDC) (in England, Wales and Northern Ireland) or the NHS Board consultant in health protection (in Scotland)[3]
- once the bagged body is placed in the leak-proof/sealed coffin, no additional cleaning is needed unless leakage has occurred. In the event of leakage of fluids from the body bag, thoroughly clean and decontaminate areas of the environment with suitable disinfectants (see ACDP guidance for detail on management of this scenario[2])
- following the removal of the body, the deceased's room should be cleaned and disinfected, and reusable equipment cleaned/disinfected as per the ACDP guidance[2]
- in addition to the information provided on the infection control notification sheet, it is advised that the funeral director discusses appropriate infection control procedures, use of personal protective equipment (PPE) and waste disposal arrangements with specialists[3], such as the local HPT (in discussion with the Imported Fever Service/RIPL), the HLIU consultant and the Royal College of Pathologists

### Embalming or hygienic preparation

Although it is recognised that in most other circumstances in the UK, bodies often receive some form of hygienic preparation or are fully embalmed as a means of delaying putrefaction (eg when a funeral is delayed or for transportation over long distances within the UK or internationally), this is **not appropriate** for Ebola-infected remains. In the case of confirmed Ebola cases, embalming or hygienic preparation of bodies presents an unacceptably high risk of occupational exposure to Ebola virus and should not be undertaken[2].

### The return of the deceased's clothing and personal effects to relatives

In principle clothing, personal effects and valuables may only be returned to relatives (in accordance with normal health service procedure) following satisfactory evidence (eg from the NHS locally if a hospital death) that all potentially contaminated material has been successfully decontaminated in the following manner[2]:

- articles of clothing and similar items visibly contaminated should be safely disposed of
- other items of clothing should be autoclaved prior to laundering
- wedding rings, jewellery and other physical artefacts should either be autoclaved or decontaminated using a validated disinfectant. They can then be returned to relatives of the deceased

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    - the Ebola virus is susceptible to chlorine[2]; therefore, bleach (sodium hypochlorite) is a suitable disinfectant for cleaning purposes. It is important to ensure that any disinfectants used in the decontamination procedure have been validated as effective against blood-borne viruses. See Appendix 10 of the ACDP guidance for specific detail on decontamination
- relatives should be alerted that some clothing fabrics and materials from which personal effects are made (eg plastics) may be adversely affected or even destroyed by autoclaving or disinfection[2]. In such cases, with the agreement of relatives, subsequent disposal may be the preferred option

## Viewing of the deceased and funeral arrangements

While the needs and wishes of the relatives of the deceased must be taken into consideration when arranging disposal of the remains of an Ebola-infected person, they should not detract from the infection-control procedures in place, which aim to limit contact with the body[2,3],and seek to ensure the remains are promptly cremated or buried, to prevent further risk of spread of infection from the remains

- the following will need to be prohibited in order to prevent exposure of bereaved persons and relatives to the deceased: all religious/ritual preparation of the body by washing, dressing, viewing, touching or kissing of the deceased[2,3]
- discussion around these areas with the relatives must be conducted in a sensitive but firm manner by an appropriate individual, in an appropriate setting and with the appropriate amount of time set aside for the discussion[3]
- if there are any concerns about risk assessment, the funeral director should discuss with the Registered Medical Practitioner or their local HPT (see the PHE postcode lookup to find the local HPT) to assist in this process with the next of kin and those making funeral arrangements

## Individuals transporting human remains

PPE is not required for individuals driving (or a passenger) in a vehicle carrying the human remains of an Ebola case, provided that the remains are cremated remains, or are remains safely contained in a double body bag within an approved leak-proof closed robust coffin eg zinc-lined coffin, soldered closed and with sealed joints OR an appropriately leak-proof double fill cremfilm[4]-lined coffin.

## Repatriation of human remains from Ebola-affected countries

The cross-border transportation of human remains is governed by three different authorities:

- the country of destination (normally regarded as being the body of law that controls how the remains should be handled as regards control of infection[3])
- the country of origin

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- the carrier (whose requirements will be governed by the International Air Transport Association (IATA) Restricted Articles Regulations)

Any transportation should be co-ordinated in advance with the relevant authorities. Under the International Health Regulations, the cross-border movement of the human remains of deceased suspect, probable or confirmed Ebola cases is **prohibited** unless authorised in accordance with recognised international biosafety provisions (World Health Organization statement, August 2014).

Biosafety provisions for cross-border movement, if authorised, would usually require a body to be embalmed and contained in a leak-proof double body bag within a hermetically sealed zinc-lined transport coffin in accordance with IATA requirements. Upon arrival in the UK, a change of coffins should be avoided and burial[5] promptly arranged after arrival[3]; the coffin should not be opened prior to committal or interment.

The ACDP guidance advises that Ebola-infected bodies should not be embalmed on grounds of the high risk of infection to the embalmer. This makes it difficult to achieve full compliance with IATA requirements and therefore cross-border transportation of Ebola-infected bodies **should not be undertaken. The bodies should be cremated locally**. Following cremation, ashes may be safely transported.

It is possible that funeral directors in the UK may receive requests from companies or organisations regarding the repatriation of the remains of UK workers from Ebola-affected countries for burial. If such a request is made, the funeral director involved should discuss the case with their local HPT (see postcode lookup), but it should be made clear to anyone enquiring that the cross-border transportation of Ebola-infected bodies should not be undertaken and that instead the body should be cremated locally and the ashes repatriated as outlined above.

### 'Freedom from infection' certificate

Under the International Air Transport Association (IATA) Restricted Articles Regulations, human remains crossing borders need to be accompanied by a notification of infection form or 'Freedom from Infection' Certificate. The 'Freedom from Infection' Certificate, if issued, confirms that no infectious diseases of epidemic proportions occurred within the district where the body is coming from, for a specified time period preceding death; it confirms that the *district* is 'free from infection', not that the deceased is 'free from infection'. There are no standard IHR documents to declare a dead body free from infection.

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[5] As a zinc-lined coffin cannot be cremated, the recommendation to avoid changing coffins dictates the requirement for burial rather than cremation

It would be very unlikely that this certificate could be produced for human remains being repatriated from any district in the Ebola-affected countries of Liberia, Guinea or Sierra Leone in the current outbreak; even if the deceased is not a suspect Ebola case, most districts in these three countries are/have been affected by the current Ebola outbreak, so could not be declared 'free from infection'. This lack of relevant documentation to accompany the remains provides a further barrier to repatriation, in addition to the prohibition (under the International Health Regulations) of cross-border movement of the remains of deceased Ebola cases in the current outbreak.

## Statutory requirements

### I. Informing the chief coroner

The chief coroner has issued guidance advising that he should be informed if a death from Ebola occurs. PHE will advise on a case-by-case basis on the repatriation of the mortal remains of any HMG civilian who dies of EVD in Sierra Leone. The same arrangement will apply if patient dies of EVD anywhere other than the Royal Free Hospital. If such a death occurs, DH is requested to inform the chief coroner's office by email to chiefcoronersoffice@judiciary.gsi.gov.uk

### II. 'Notification of infectious disease' requirements

Under the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010, there is a statutory requirement to report urgently (within 24 hours) suspected or confirmed cases of Ebola virus disease to the 'proper officer'. In England, the designated proper officer is the consultant in communicable disease control (CCDC) or health protection in the HPT of the area of residence of the case (or the deceased) (see the PHE postcode lookup). The reporting responsibility/duty falls both on:

- the RMP attending the case – reporting should be **immediately on clinical suspicion** of a viral haemorrhagic fever syndrome
  - OR, if a RMP[6], the coroner (or their coroner's officer) which first has information about the death[3]
  - OR, if the case is referred to post-mortem (without the diagnosis being suspected), the pathologist tasked with conducting that post-mortem
- the laboratory confirming Ebola virus infection (even if the case has already been notified by the RMP)

The RMP, coroner, coroner's officer or pathologist should not wait for laboratory confirmation or results of other investigations in order to notify a suspect case. If laboratory test results refute the clinical diagnosis later, the RMP (or other parties involved) is not required to de-notify the case.

[6] In England & Wales, a coroner must be an experienced lawyer or a doctor, and in some cases are both

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## III. Controlling the risk of exposure

Public health law in England, through the Health Protection (Local Authority Powers) Regulations 2010, provides for steps to be taken (as may be reasonably practicable) to prevent, where necessary, persons coming into contact with, or in proximity to, the body of a person who has died from/with a notifiable infectious disease such as Ebola[2]. The regulations give discretionary powers to local authorities to restrict *contact* or *access* by serving a notice on the person having charge or control of the premises in which the remains are located.

If such a notice is served, a copy of the notice must be conspicuously displayed, either near the remains (if the notice restricts *contact with* the body; for example, on the casket), or at each of the entry points to the room in which the remains are located (if the notice restricts *access to* the body).

## IV. Cremation

The Ministry of Justice Guidance for cremation authorities and crematorium managers (2012) outlines the responsibilities for cremation authorities under the requirements of The Cremation (England and Wales) Regulations 2008. Under these regulations, and under normal circumstances, after the application for cremation of the remains of a deceased person (Form Cremation 1) has been submitted, the applicant has a right to inspect the medical certificates (Forms Cremation 4 and Cremation 5) before the medical referee authorises cremation; the certificates must be available for inspection at the offices of the cremation authority for a 48-hour period, and should take place at least 24 hours before the funeral is due to take place.

The right of inspection no longer applies if the case has been referred to a coroner and they have issued Form Cremation 6. The coroner's support can also be sought for speedy cremation, even if the case doesn't fit the usual criteria for referring to the coroner.

## Further help and guidance

Further information on Ebola virus disease can be found at: Ebola virus disease: clinical management and guidance.

To find out how to contact the HPT for your area, visit http://legacytools.hpa.org.uk/AboutTheHPA/WhatTheAgencyDoes/LocalServices/PostcodeSearch/

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