

# Form for the Diagnosis of Death using Neurological Criteria

## {short version}

This form is consistent with and should be used in conjunction with, the AoMRC (2008) A Code of Practice for the Diagnosis and Confirmation of Death and has been endorsed for use by the Intensive Care Society and the Faculty of Intensive Care Medicine.

HOSPITAL ADDRESSOGRAPH or

Surname  
First Name  
Date of Birth  
NHS / CHI Number

### Evidence of Irreversible Brain Damage of known Aetiology

**Primary Diagnosis (known aetiology):**

**Evidence of Irreversible Brain Damage:**

**Red Flag Present?**

Diagnostic caution is advised in certain 'Red Flag' patient groups. See Page 3.  
If YES, document how the Red Flag was mitigated on Page 2.

Yes / No

### Exclusion of Reversible Causes of Coma and Apnoea

	1 <sup>st</sup> Test Dr One	1 <sup>st</sup> Test Dr Two	2 <sup>nd</sup> Test Dr One	2 <sup>nd</sup> Test Dr Two
Is the coma due to depressant drugs? Consider: dose, duration, drug clearance, need for antagonist / drug levels.	Yes / No	Yes / No	Yes / No	Yes / No
Is the patient's body temperature less than or equal to 34°C?	Yes / No	Yes / No	Yes / No	Yes / No
Is the coma due to a circulatory, metabolic or endocrine disorder?	Yes / No	Yes / No	Yes / No	Yes / No
Is the apnoea due to neuromuscular blocking agents, other drugs or a non brain-stem cause? Consider: cervical injury, any neuromuscular weakness.	Yes / No	Yes / No	Yes / No	Yes / No

### Tests for Absence of Brain-Stem Reflexes

	1 <sup>st</sup> Test Dr One	1 <sup>st</sup> Test Dr Two	2 <sup>nd</sup> Test Dr One	2 <sup>nd</sup> Test Dr Two
Do the pupils react to light?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any eyelid movement when each cornea is touched in turn?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any motor response when supraorbital pressure is applied?	Yes / No	Yes / No	Yes / No	Yes / No
Is the gag reflex present?	Yes / No	Yes / No	Yes / No	Yes / No
Is the cough reflex present?	Yes / No	Yes / No	Yes / No	Yes / No
Is there any eye movement during or following caloric testing in each ear?	Yes / No	Yes / No	Yes / No	Yes / No

Brain-Stem Reflexes

Please circle as appropriate

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Patient Name:

NHS / CHI Number:

Apnoea Test

Apnoea Test				
	1 <sup>st</sup> Test Dr One	1 <sup>st</sup> Test Dr Two	2 <sup>nd</sup> Test Dr One	2 <sup>nd</sup> Test Dr Two
Arterial Blood Gas pre apnoea test check: (Starting PaCO <sub>2</sub> greater than or equal to 6.0 kPa and starting pH less than 7.4 or [H <sup>+</sup> ] greater than 40 nmol/L)	1 <sup>st</sup> Test Starting PaCO <sub>2</sub> :  Starting pH/[H <sup>+</sup> ]:		2 <sup>nd</sup> Test Starting PaCO <sub>2</sub> :  Starting pH/[H <sup>+</sup> ]:	
Is there any spontaneous respiration within 5 (five) minutes following disconnection from the ventilator?	Yes / No	Yes / No	Yes / No	Yes / No
Arterial Blood Gas Result post apnoea test: (PaCO <sub>2</sub> should rise greater than 0.5 kPa)	1 <sup>st</sup> Test Final PaCO <sub>2</sub> :  <i>Perform lung recruitment</i>		2 <sup>nd</sup> Test Final PaCO <sub>2</sub> :  <i>Perform lung recruitment</i>	
Document any Ancillary Investigations / Mitigations for Red Flags / Unavoidable Clinical Variance from AoMRC (2008) Guidance				
Completion of Diagnosis				
Are you satisfied that death has been confirmed following the irreversible cessation of brain-stem-function?	YES / NO		YES / NO	
Legal time of death is when the 1 <sup>st</sup> Test indicates death due to the irreversible loss of brain stem function.  Death is confirmed following the 2 <sup>nd</sup> Test.  Where required four different medical practitioners can make the diagnosis provided each pair fulfils the AoMRC requirements (Page 3).	<b>Date:</b> <b>Time:</b>  <b>Dr One</b> Name Grade GMC Number Signature  <b>Dr Two</b> Name Grade GMC Number Signature		<b>Date:</b> <b>Time:</b>  <b>Dr One</b> Name Grade GMC Number Signature  <b>Dr Two</b> Name Grade GMC Number Signature	

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*It remains the duty of the two doctors carrying out the testing to be satisfied with the aetiology, the exclusion of all potentially reversible causes, the clinical tests of brain-stem function and of any ancillary investigations so that each doctor may independently confirm death following irreversible cessation of brain-stem function.*

## Guidance Summary of the AoMRC Code of Practice

The diagnosis of death by neurological criteria should be made by at least two medical practitioners who have been registered for more than five years (registration can be outside the UK) and are competent in the conduct and interpretation of brain-stem testing. At least one of the doctors must be a consultant. Testing should be performed completely and successfully on two occasions with both doctors present. It is recommended that one doctor perform the test while the other doctor observe; roles may be reversed for the second test.

## Diagnostic caution is advised in the following 'Red Flag' patient groups.

Consider the need to delay testing and/or perform ancillary investigations.

1. Testing < **6 hours** of the loss of the last brain-stem reflex
2. Testing < **24 hours** of the loss of the last brain-stem reflex, where aetiology primarily anoxic damage
3. **Hypothermia** 24 hour observation period following re-warming to normothermia recommended
4. Patients with **any neuromuscular disorders**
5. **Steroids** given in space occupying lesions such as abscesses
6. Prolonged **fentanyl** infusions
7. Aetiology **primarily** located to the **brain-stem or posterior fossa**
8. Therapeutic **decompressive craniectomy**

## Evidence for Irreversible Brain Damage of Known Aetiology

- There should be no doubt that the patient's condition is due to **irreversible brain damage of known aetiology**. It may take a period of continued clinical observation and investigation (e.g. neuroimaging or neurophysiological evidence) to be confident of the irreversible nature of the prognosis. The timing of the tests should be appropriate for the reassurance of all those directly concerned. **If in doubt, wait and seek advice.**

## Children (one examining doctor should normally be a paediatrician or should have experience with children and one of the doctors should not be primarily involved in the child's care)

- **Older than 2 months post term:** guidance as per adult testing forms. Recommended paediatric [form available](#).
- **Between thirty seven weeks corrected gestation (post menstrual) age to 2 months of age post term:** use the RCPCH Guidance available at [www.rcpch.ac.uk](http://www.rcpch.ac.uk). [Form available](#).
- **Infants less than 37 weeks corrected gestation (post menstrual) age:** the concept of 'brain-stem death' is inappropriate for infants in this age group.

## Drugs – There should be no evidence that the coma or apnoea is due to depressant drugs.

- The length of time between discontinuation of depressant drugs and undertaking brain-stem testing depends on several factors including total dose, duration of treatment and the underlying renal and hepatic function. If opioids or benzodiazepines cannot be excluded as contributing to the coma, specific antagonists such as naloxone or flumazenil should be used. Where there is any doubt specific drug levels should be carried out (midazolam less than < 10mcg/L, thiopentone <5mg/L). Alternatively consider ancillary investigations.
- There must be no residual effect from any neuromuscular blocking agents. Where there is doubt consider the use of peripheral nerve stimulation or reversal agent.

## Temperature, Circulatory, Metabolic or Endocrine Disorders

- Temperature must be > 34°C. In the hours prior to testing aim for mean arterial pressure >60mmHg (or age appropriate parameters for children) and normal respiratory parameters *if possible* (PaCO<sub>2</sub> <6.0 kPa, PaO<sub>2</sub> >10 kPa and pH 7.35 –7.45 / [H<sup>+</sup>] 45-35 nmol/L).
- Serum Na<sup>+</sup> should be between 115-160mmol/L; Serum K<sup>+</sup> should be > 2mmol/L; Serum PO<sub>4</sub><sup>3-</sup> and Mg<sup>2+</sup> should not be profoundly elevated (>3.0mmol/L) or lowered (<0.5mmol/L) from normal.
- Blood glucose should be between 3.0-20mmol/L before each brain-stem test.
- If there is any clinical reason to expect endocrine disturbances, then it is obligatory to ensure appropriate hormonal assays are undertaken.

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## Brain Stem Reflexes

- Pupils should be fixed in diameter and unresponsive to light.
- There should be no corneal (blink) reflex (care should be taken to avoid damage to cornea).
- Eye movement should not occur when each ear is instilled, over one minute, with 50mls of ice cold water, head flexed 30°. Each ear drum should be clearly visualised before the test.
- There should be no motor response within the cranial nerve or somatic distribution in response to supraorbital pressure. Reflex limb and trunk movements (spinal reflexes) may still be present.
- There should be no gag reflex following stimulation to the posterior pharynx or cough reflex following suction catheter placed down the trachea to the carina.

## Apnoea Test

- End tidal carbon dioxide can be used to guide the starting of each apnoea test but should not replace the pre and post arterial  $\text{PaCO}_2$ .
- Oxygenation and cardiovascular stability should be maintained through each apnoea test.
- **Confirm  $\text{PaCO}_2 \geq 6.0$  kPa and  $\text{pH} < 7.4$  /  $[\text{H}^+] > 40$  nmol/L.** In patients with chronic  $\text{CO}_2$  retention, or those who have received intravenous bicarbonate, confirm  $\text{PaCO}_2 > 6.5$  kPa and the  $\text{pH} < 7.4$  /  $[\text{H}^+] > 40$  nmoles/L.
- Either use the recommended method of CPAP circuit (eg Mapleson C) or disconnect the patient from the ventilator and administer oxygen via a catheter in the trachea at a rate of  $> 6$  L/minute.
- There should be no spontaneous respiration within a minimum of 5 (five) minutes following disconnection from the ventilator.
- **Confirm that the  $\text{PaCO}_2$  has increased from the starting level by more than 0.5 kPa.**
- At the conclusion of the apnoea test, manual recruitment manoeuvres should be carried out before resuming mechanical ventilation and ventilation parameters normalised.

## Ancillary Investigations

- Ancillary investigations are **NOT** required for the diagnosis and confirmation of death using neurological criteria. Any ancillary or confirmatory investigation should be considered **ADDITIONAL** to the fullest clinical testing and examination carried out to the best of the two doctors' capabilities in the given circumstances.

## Organ Donation

- National professional guidance advocates the confirmation of death using neurological criteria wherever this seems a likely diagnosis and regardless of the likelihood of organ donation.
- NICE guidance recommends that the specialist nurse for organ donation (SN-OD) should be notified at the point when the clinical team declare the intention to perform brain-stem death tests and this is supported by GMC guidance.

## References & Resources

Academy of Medical Royal Colleges (2008) "A Code of Practice for the Diagnosis and Confirmation of Death" [www.aomrc.org.uk](http://www.aomrc.org.uk)

Gardiner D, Shemie S, Manara A & Opdam H (2012) "International perspective on the diagnosis of death" *BJA* 108 Suppl 1:i14-28.

GMC (2010) "Treatment and care towards the end of life." [www.gmc-uk.org](http://www.gmc-uk.org)

Heran *et al* (2008) "A review of ancillary tests in evaluating brain death." *Can J Neurol Sci*; 35:409-19

NICE (2011) "Organ Donation for Transplantation" [www.nice.org.uk](http://www.nice.org.uk)

Report from the Organ Donation Taskforce (2008) "Organs for Transplant" [www.webarchive.nationalarchives.gov.uk](http://www.webarchive.nationalarchives.gov.uk)

Wijdicks E (2001) "The Diagnosis of Brain Death" *NEJM* 344:1215-21.

A series of helpful education videos are available: <https://www.odt.nhs.uk/deceased-donation/best-practice-guidance/donation-after-brainstem-death/diagnosing-death-using-neurological-criteria/>.

## Form authorship and feedback

This form was written by Dr Dale Gardiner, Nottingham and Dr Alex Manara, Bristol. Comments should be directed to [dalegardiner@doctors.net.uk](mailto:dalegardiner@doctors.net.uk)