confirmation of death.¹

There is some evidence to suggest that these guidelines are not followed.² We decided to find out whether GPs were aware of these guidelines and used them in clinical practice.

An e-mail was sent to 277 GPs in Dumfries and Galloway inviting them to participate in an online questionnaire regarding death confirmation. The questionnaire described a clinical scenario followed by questions on how death was confirmed. The survey also asked whether they were aware of the guidelines.

Eighty-six GPs responded: a response rate of 31%. Only 12 (14%) were aware of the guidelines.

The guidelines recommend assessing for the absence of a circulation for 5 minutes. Twenty-two (26%) responders said that they would assess for the absence of a circulation for 5 minutes or more and 42 (49%) would only assess for 1 minute.

Following 5 minutes of cardiorespiratory arrest, the guidelines recommend assessing the pupillary response to light, the corneal reflex, and the motor response to supra-orbital pressure. Eighty-three (97%) of responders said they would assess the pupils but only 14 (16%) checked the corneal reflex and 14 (16%) checked the response to supra-orbital pressure.

Prior to the publication of the 2008 guidelines, there was no formal guidance on how to confirm death following cardiorespiratory arrest. Practice varied from confirming death as soon as the heart stops to waiting 10 minutes or more.¹ Many textbooks do not describe how to confirm death³ and *The Oxford Handbook of Clinical Medicine* published in 2010 describes the diagnosis of death in the following way: 'Apnoea with no pulse and no heart sounds and fixed pupils'.⁴

It is apparent that GPs in Dumfries and Galloway are not following these guidelines. Indeed the vast majority are unaware of this guidance. Does this matter? Diagnosis of death requires 'confirmation that there has been irreversible damage to the brain-stem, due to the length of time in which the circulation is absent'¹ and an assessment for only 1 minute is likely to be inadequate.

How could this be improved? These guidelines were distributed to medical directors of NHS trusts/boards for dissemination to relevant personnel. It is recognised that passive dissemination is ineffective and multifaceted approaches may be required to change practice.⁵

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Recording concerns about child maltreatment

The recommended coding pathway, using a universal safeguarding code 'child is cause for concern' (with additional codes where indicated), as recommended by the RCGP Multisite Safeguarding Audit team,¹ has the potential to increase significantly the amount and consistency of safeguarding information recorded in primary care.

The universal code chosen would need to have a SNOMED CT^{®2} equivalent or an application to have this term requested from the UK Terminology Centre. The team identified one of the barriers to recording safeguarding concerns is 'the disincentive to

use permanent and potentially stigmatising codes that could be seen by patients and parents'. I would be interested to know if the team have, or plan to, conduct any research on the views of parents regarding coding and the universal term chosen. Although I would feel confident using the 'child is cause for concern' code where I would also code child protection plans and other significant family events such as domestic violence, I would hesitate to use this particular code for recording family risk factors where there is not a current concern about the parenting ability.

A single universal code would be ideal; if however, a suitable term could not be found to cover all situations, perhaps one term relating to actual child protection procedures and a second term to be used for recording 'risk' would increase recording. 'Family with young children' is a SNOMED CT which could be used in parents' notes to ensure any children in the household are kept in focus when the parent is seen.

GMC advice³ states 'You must record your concerns, including minor ones, in the child's or young person's records (and in their parents' records ...)'. Pertinent family information including parental risk factors can be recorded in the child's records.⁴ A coding pathway would need to clarify how to record this information so that it is easily seen, but not inadvertently shared, for example in a referral letter which has imported the child's problem list. An IT solution could be developed to avoid any risk of accidental disclosure and remove this potential barrier to recording.

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