

NHS BLOOD AND TRANSPLANT

National Organ Donation Committee – Subgroup Meeting

Impact of Suitability Assessment for DCD Donation Guidance on Predicting Imminent Death Following Treatment Withdrawal

Introduction

1. This paper investigates whether the introduction of the Suitability Assessment for DCD Donation (FRM7814) guidance on predicting imminent death in DCD donation, released in April 2025, has affected the ability to predict imminent death following treatment withdrawal. This paper presents a retrospective analysis comparing a period before and after the introduction of the guidance. This analysis includes a comparison of the calculated sensitivity and specificity for correctly predicting imminent death for the two time periods.

Definitions

2. The following definitions are used throughout this report:

Time to Death is defined as time between withdrawal of life sustaining treatment (WLST) and time of death or 30 days post-WLST/hospital discharge for those alive post-WLST.

Neurological Death Criteria (NDC) is defined as a patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex.

Absolute Contraindication (ACI) is defined as an absolute medical contraindication identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: [Clinical contraindications to approaching families for possible organ donation - POL 188.](#)

SNOD A member of Organ Donation Services (ODS) Team including Team manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse.

Referred to SNOD A patient who was referred to a SNOD to determine organ donation suitability.

Data

3. Data on all referred patients, between 1 July 2024 and 31 December 2024 and the comparative period in 2025, where the patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, have been obtained from the UK Potential Donor Audit (PDA). PDA data were extracted on 7 January 2026.

Results

4. **Table 1** and **Table 2** present the numbers of referrals where a patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, July - December 2024 and July - December 2025, respectively. Time to death was missing in 21 and 14 cases, respectively where either time of WLST or death was unknown/erroneous. The sensitivity (proportion of people who die within four hours where imminent death was anticipated) has remained high across both periods, 89% (1962/2209) and 88% (1951/2215), respectively. The specificity (proportion of people who die after four hours where imminent death was not anticipated) remains low in both periods, but has increased in the most recent period, 38% (411/1082) to 43% (484/1124).

Table 1 All referrals where patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, 1 July - 31 December 2024			
Time to death	Imminent death anticipated		Total
	Yes	No	
0 - <4 hrs	1962	247	2209
≥ 4 hrs*	671	411	1082
Total	2633	658	3291
Missing	20	1	21
*Includes 28 patients that were alive at 30-days post-WLST/discharge			

Table 2 All referrals where patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, 1 July - 31 December 2025			
Time to death	Imminent death anticipated		Total
	Yes	No	
0 - <4 hrs	1951	264	2215
≥ 4 hrs*	640	484	1124
Total	2591	748	3339
Missing	10	4	14
*Includes 68 patients that were alive at 30-days post-WLST/discharge			

5. **Table 3** shows the demographics of referred patients where the patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, 1 July - 31 December 2024 and 2025. There has been no change between 2024 and 2025 in proportion of patients across age, cause of death, time to death and if the patient had an ACI.

Table 3 Patient demographics of all referrals where patient was mechanically ventilated, not confirmed dead by NDC and treatment was withdrawn, 1 July - 31 December 2024 and 2025				
Factor	Jul-Dec 2024		Jul-Dec 2025	
	N	%	N	%
Age (P-value ¹ = 0.83)				
0-17	113	3	115	3
18-29	94	3	98	3
30-39	182	5	160	5
40-49	311	9	330	10
50-59	588	18	622	19
60-69	842	25	847	25
70-80	1182	36	1181	35
Cause of death (P-value ¹ = 0.13)				
Hypoxic brain damage	1080	33	1174	35
Intracranial haemorrhage	819	25	838	25
Multi-organ failure	517	16	473	14
Intracranial thrombosis	210	6	222	7
Respiratory	171	5	131	4
Infection/Sepsis	86	3	109	3
Cancer other than brain tumour	119	4	106	3
Cardia/Vascular	81	2	70	2
Trauma	66	2	62	2
Poisoning/Overdose	6	0	8	0
Miscellaneous	97	3	97	3
Other	60	2	63	2
Time to death (P-value ¹ = 0.38)				
0 - <4 hrs	2209	67	2215	66
≥ 4 hrs*	1082	33	1124	34
Missing	21	1	14	0
ACI (P-value ¹ = 0.12)				
No ACI	2316	70	2404	72
ACI	996	30	949	28
Total	3312		3353	
¹ P-values were calculated using Pearson's chi-square tests comparing demographic characteristics between 2024 and 2025. A two-sided p-value <0.05 was considered statistically significant.				
*Includes patients that were alive at 30-days post-WLST/discharge				

Summary

- The prediction of imminent death within four hours, in patients where imminent death occurs, has remained consistently high following the introduction of the Suitability Assessment for DCD Donation guidance. Between July and December 2025, 88% of patients who died within four hours were correctly predicted to do so. The ability to correctly predict prolonged time to asystole (PTA) has improved slightly from 38% to 43% of PTA cases.

7. Patient case-mix was similar across the two comparative periods, for the demographics considered, with no statistically significant differences in age, cause of death, time to death or if the patient had an ACI.

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