ICP
International Classification of Dying Places

A common metric to classify where
people die and are cared for at the end of life

"Dying is a process. Death is an event.
The first may proceed in several places but the latter occurs at one place only." (Ward, 1974)

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Contents

Chapter 1. Introduction

Purpose of the ICP

The *International Classification of Dying Places* (ICP) provides a standard framework and language to describe and understand "dying places" – this term comprises both the places where people die (places of death) and the places where people are cared for at the end of their life (places of end of life care). These include not only hospitals and private residences but also places like hospices, prisons, long-term care facilities, the street or even vehicles, among others. While death is a single life event that occurs at one place only and can happen unexpectedly, in the majority of cases someone's end of life evolves for weeks or months due to a disease.[1] This may involve receiving care in several places. The distinction between places of death and places of end of life care, originally made by Audrey Ward in 1974 in the context of terminal care in malignant disease in the UK,[2] applies anywhere in the world. The array of possible (dying) places is nonetheless common, applicable to both places of death and places of end of life care, and the ICP intends to depict it in the most meaningful manner.

Why are dying places important?

Place of death is a vital statistic, important for guiding health and social policy and resources allocation to ensure the existence of services and support (including palliative care) where people die.[3] Globally, an estimated 27 million people die every year with serious health-related suffering that could benefit from palliative care, and this number is estimated to double by 2060.[2,4] Place of death is also relevant to other causes of death, including injuries and self-harm, for example.[5]

Whenever possible, a person should die and also be cared for at the end of life where they feel it is the right place to be.[6] Thus, data on dying places reveal how health systems and societies fail or succeed in supporting patient and family preferences about place of end of life care and death. Nee.[7] However, the reality does not always align with people's preferences and pandemics stir patterns, as shown with COVID-19.[8,9] Closely monitoring where people die is, therefore, crucial to ensure better care.

The need for an international classification

The ICP responds to a fundamental need for an internationally agreed and standardized approach to classify statistical data on dying places. At the centre of this need stands the recording of place of death at a population level; this is already part of death certificates or registrations in many countries.[8] As a result, in the past 6 decades we have seen nearly 20

studies drawing together death certificate data on place of death from 91 countries.[10-13] This is important research as it can reveal cross-national commonalities and differences in trends and determinants of where people spend their last hours of life. However, current classifications are incomplete and inconsistent. This leads to country comparisons often being restricted to dying at home compared to hospitals or health institutions, and even these fall short of rigor because of variation in categories and in what is included in each category.[8, 14] Moreover, the amount of missing data is an important caveat in current place of death information. In 107 million people who died in 35 countries in 2012-21, 11·5% died at an ill-defined place (unknown or undefined), which means for 1 in every 10 persons we do not know where they died.[15] This reflects the dearth of attention that place of death has received in comparison with other vital metrics (e.g., cause of death). Due to such shortcomings, so far, we have merely scratched the surface of place of death. Hence our calls to standardize records, to ensure we take the most out of place of death statistics to improve care, health and death.[3,15]

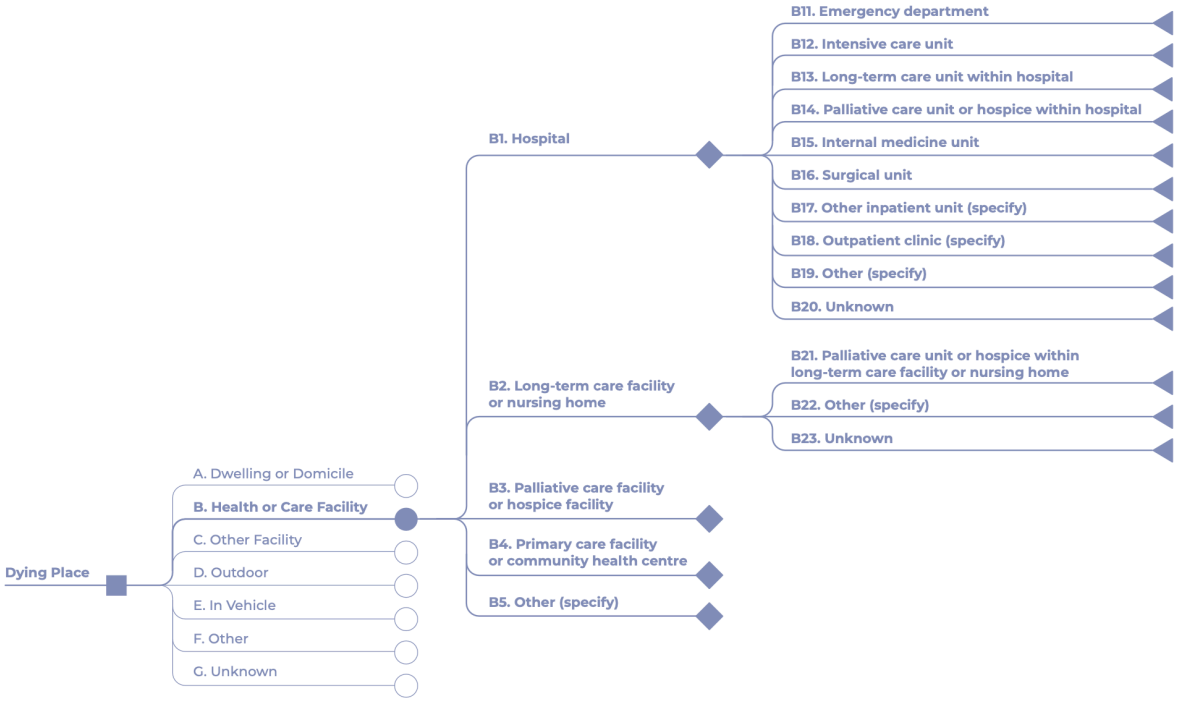
A major global classification reform and a contemporary international classification are opportunities to harmonize information so that comparable data can be obtained across countries. Now is the time to pursue this reform, in light of the fast-growing palliative care need in a post-pandemic world.[1,4] The potential value to quantify and qualify death is huge and covers all humans. It can radically change records and help improve care globally.

What does the ICP look like?

The ICP provides a comprehensive list of dying places that groups them according to a hierarchical system designed to be meaningful for individuals, responding to what is known about preferences for places of end of life care and death. The ICP therefore looks beyond the medical aspects to represent the social, emotional, and personal meanings attached to where people spend their final months, weeks, days and hours of life (e.g., related to feelings of safety, privacy, sense of identity and social connection, in particular with family life).[16-18]

Compared to other health classifications, the ICP has a smaller set of categories and sub-categories divided into seven chapters, designated from A to G (Figure 1). Together they capture nearly all the variation in dying places. The shortness of the ICP, with an estimated time of completion that ranges from seconds to a few minutes, increases the chances of it being used in practice. The list is intended to be as contemporary as possible, but it is open to update with dying places that may emerge as important in the future.

Figure 1. Broad structure of the ICP, expanding the largest chapter as example

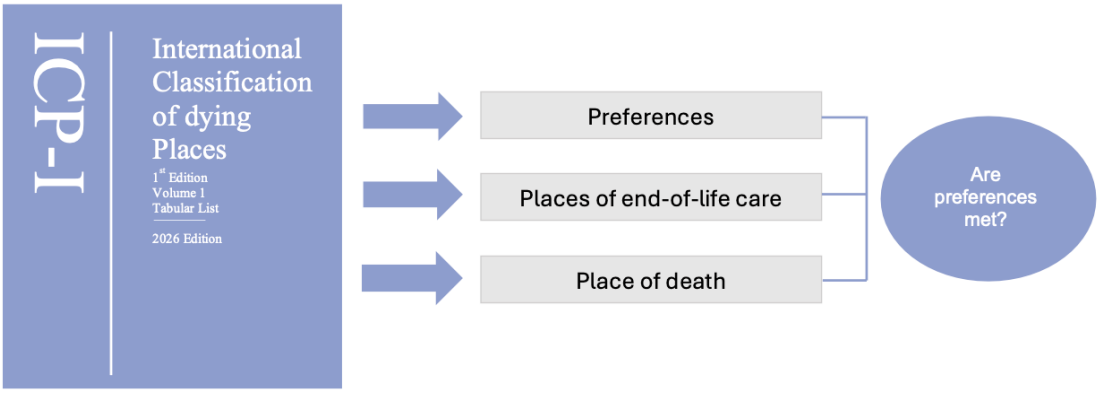


Some of the chapters have qualifiers that provide additional relevant details. The most common qualifier (applicable to all chapters except residuals) captures whether the dying place is/was the person's workplace. An important subjective qualifier (applicable to the first two chapters) captures whether the dying place is/was regarded by the person as their home. Answer options are "yes", "no" or "don't know".

How can the ICP be used?

The ICP is a multi-purpose classification intended for use with different purposes (Figure 2) and by different user groups. At its core is the use by medical doctors to record place of death in death certificates. The ICP can also be used to record places of end of life care and preferred places of end of life care and death, by health and care professionals in their routine care practice (in clinical records), and by researchers in studies about preferred and/or actual dying places (in surveys). Having a finely grained common metric used by all these user groups for different purposes will enable far better comparisons of preferred and actual places, to identify alignment (e.g., preference for place of death met or not).

Figure 2. Multi-purpose use of the ICP



Beside enabling key developments such as measurement of progress towards achievement of preferences when care can be planned in advance, the use of the ICP to record places of end of life care and death (in death records, clinical records, or/and research studies) allows to flag situations of concern (e.g., hospitals with high percentage of people dying in corridors) and map mortality trends in high-tech environments (e.g., intensive care units),[19] congregate living places (e.g., prisons) or in units or facilities designed for specific groups (e.g., psychiatry, pediatrics). It can also help better control sudden causes of death by knowing their location (e.g., patterns of ambulance death in myocardial infarction). It can map critical places (e.g., deaths in emergency departments)[20] and ensure public health surveillance (e.g., deaths at workplaces). Importantly, it can identify people dying in critical places for ageing societies (e.g., long-term care facilities or nursing homes, hospice or palliative care facilities).[9,19,21,22]

The process of building the ICP

The first draft of the ICP was developed by the EOLinPLACE team in May 2024, in the third year of the EOLinPLACE Project: 'Choice of where we die: a classification reform to discern diversity in individual end of life pathways', which is funded by the European Research Council.[23] The development work combined classic methods of developing health and statistical classifications,[24,25] with a bottom-up participatory research approach,[26] whereby the EOLinPLACE team of researchers (interdisciplinary and international, involving Portugal, the Netherlands, Uganda and the USA) worked with patient and family representatives, namely the International Alliance of Patients' Organizations and Eurocarers (project partners). Together, we have developed the ICP grounded in mixed-methods cross-national evidence on dying places gathered and originally generated by the EOLinPLACE Project,[7, 8, 10, 15, 20-22,27-30] counseled by an international advisory group of leading researchers, policy-makers and relevant international associations that represent patients, formal and informal caregivers (described in page 2).

The ICP structure, chapters, categories and sub-categories have been defined through a process of clustering places. This was initiated by and grounded on EOLinPLACE findings from a comparative analysis of population-based death certificate data on place of death in 35 countries[8] and an umbrella review of 229 studies on preferences for place of end-of-life care and death from patients and family members.[7] Our work also took into account the distinction (based on subjective perception) between *places* and *non-places*, by the French anthropologist Marc Augé;[31] *places* being spaces where people live in and that empower their identity, and *non-places* being spaces of transience where humans remain anonymous. Other concepts that became relevant to capture as the ICP evolved were: 1) the distinction between *outdoor* and *indoor* spaces, 2) the idea of *community* (i.e., places where a person lives with others), 3) the idea of *purpose* (i.e., places to where a person goes with a specific purpose, for example to receive healthcare), and 4) the idea of *perennity* (i.e., places where a person always returns to).

The chapters and categories were continuously refined based on the evidence that emerged from EOLinPLACE studies conducted from 2022 to 2025: systematic reviews with conceptual models of preferred and actual places of death,[7,10] mortality statistics analyses,[8,15,20,21,22,29] survey of key research teams working with place of death data,[28] policy document analysis about content on dying places,[30] serial qualitative interviews with adult and minor patients with life-threatening conditions and their family caregivers, and a mortality followback survey with bereaved relatives. All this research was cross-national, with the latter components focused on four contrasting countries (Portugal, the Netherlands, Uganda and the USA).

Contributions to the development of the ICP were made by over 100 people in addition to the EOLinPLACE team. Fifteen international advisory group members provided feedback in meetings every six-months and additionally when necessary. Contributions were gathered from 98 key stakeholders in consultation events held between May and September 2025 at conferences of the European and African Palliative Care Associations, and online organized by IAPO and Eurocarers with representatives of patient and informal carer associations, respectively, and by the EOLinPLACE team with national agencies responsible for vital registration systems. Lastly, the content validity of the ICP has been established in international focus groups with 21 researchers, policy-makers, formal care providers, patient and family representatives, between July and September 2025. Views were obtained from people from all continents and a diverse range of countries and regions, as the ICP aims to be acceptable to a wide range of stakeholders (including possible users), fit for purpose, and appropriate for different languages and cultures.

The first draft of the ICP was presented to the UN Statistics Division Team in May 2024. Since then, the Chair of the UNCEISC (Andrew Hancock) joined the EOLinPLACE advisory group, has followed progress and contributed to our first consultation event in Helsinki. The present document was developed by the EOLinPLACE Team led by Barbara Gomes and has been reviewed by Andrew Hancock, prior to presenting the ICP at the 2025 UNCEISC Meeting, towards endorsement and inclusion of the ICP in the UN International Family of Classifications.

Chapter 2. Principles

The definition of dying places

Dying places are understood in a comprehensive manner, referring not only to the site where death occurs but also to the site(s) where a dying person receives care at life's end.[32] They therefore include places that precede death and where death happens, but exclude places subsequent to death (e.g., where autopsy, funeral, or memorial arrangements occur).

When interpreting dying places, it is important to recognize that they are not only physical locations or spaces, but relate to end of life, death and dying experiences and associated meanings, which are multi-dimensional (bio, psycho, social, spiritual). They reflect a complex network of illness-related, individual and environmental factors.[33] The full spectrum of possible dying places must therefore be captured regardless of one's health condition or cause of death, sex or age. Dying places are also captured regardless of one's geographical location, be it the country or region where the person is/was.

The unit of classification

The basic unit to be classified is the dying place, either preferred or actual, reporting to either a place of end of life care or a place of death. The statistical unit (i.e., unit of observation) is the individual dying person.

Application of the principles of statistical classification

The ICP follows "Best Practice Guidelines for Developing International Statistical Classifications", by Andrew Hancock, Chair of the UNCEISC (version November 2013)[24] and WHO guidance "World Health Organization Family of International Classifications", revised in 2021 by a Writing Group of the WHO Family International Classifications Development Committee.[25]

Special attention has been given that the following core characteristics or technical qualities have been implemented in the ICP:

Mutual exclusivity: The categories are mutually exclusive of items at the same level of the classification, i.e., each dying place can only be classified to one category. The description of each category defines the respective dying place with additional guidance by illustrative examples, inclusions and exclusions (i.e., examples of places that are included in or excluded from that category). This further clarifies category boundaries. Of all the persons who participated in consultations about the ICP, 78% said its conceptual basis is clear, i.e., the structure, logic, concepts and definitions are clear and generally make sense.

Exhaustiveness: The classification is exhaustive because nearly all possible dying places in the population are captured. Notwithstanding, the ICP includes residual categories to classify places that do not fit into the specified categories. Residual categories exist at higher and lower levels and are consistently named as “other” and “unknown”. Adding specified categories reduces residuals and ill-defined places, which we found in our earlier work to be 11·5% across 35 countries.[15] Of all persons involved in consultations, 84% said the ICP fully or mostly captures the dying places that are meaningful in their own culture.

Statistical feasibility: The classification effectively, accurately, and consistently distinguishes between categories on the basis of responses to questions that can be reasonably asked in death and clinical records or statistical surveys, to care providers and to patients themselves. To ensure suitability of the ICP for use in different settings, the classification was discussed with persons from 36 countries. Of all the persons in consultations, 89% said the ICP was acceptable to them and 92% said they would use and/or recommend others to use. 98% said the ICP is fit for purpose as an international standard, to harmonize the recording of dying places globally.

Chapter 3. Application

Classifying dying places

To implement the ICP, it is necessary to accurately allocate any dying place to one of the ICP categories. This requires knowledge of the ICP structure before attempting to classify. As the classification is hierarchical, the first step is to identify which of the seven chapters apply: A. Dwelling or Domicile, B. Health or Care Facility, C. Other Facility, D. Outdoor, E. In Vehicle, F. Other, or G. Unknown. For chapters A to E, it is then necessary to further classify into a category and sub-category when applicable.

Chapter F (Other) and categories and sub-categories represented by the word “other” in the category name represent residuals for cases in which a dying place cannot be classified in an established category. In these cases, users of the ICP are asked to specify the place in free-text. Dying places should be classified into these residuals categories only when absolutely necessary and only after a thorough review of the full classification, to ensure that a category has not been overlooked.

Annex 1 provides the detailed structure of the ICP, with definitions of each Chapter, category and sub-category. Annex 2 provides an alphabetical index of the ICP.

The use of illustrative examples, inclusions and exclusions

Some chapters, categories and sub-categories provide illustrative examples of dying places. These are common places belonging to the respective category, with the aim of providing practical guidance to classifying a specific place, distinguishing one category from another. For example, the illustrative examples under religious space or institution (A22), which is a sub-category of congregate dwelling or domicile under chapter A, include convent and monastery. Illustrative examples are not exhaustive, and the list can be expanded in the future.

When necessary, chapters, categories and sub-categories include a list of borderline cases that could belong there although they could be classified elsewhere (inclusions) or are classified elsewhere despite similarities to the category in question. For example, hospital (B1) includes facilities that provide mostly acute care (medical, nursing and/or other) and excludes long-term care facility or nursing home (B2), palliative care facility or hospice (B3) and primary care facility (B4). Each of these places have their own category within Chapter B (health and care facility).

Together, illustrative examples, inclusions and exclusions aid in reinforcing mutual exclusiveness, by clarifying the boundaries between categories to ensure each dying place is assigned to only one category.

The relationship to other international classifications

The ICP has several linkages with the International Classification of Diseases (ICD-11), which classifies place of injury occurrence, under dimensions of external causes within X extension codes. In particular, the categories for facilities other than health or care facilities (Chapter C) and outdoor (Chapter D) mirror ICD categories, but with less level of detail. For example, in the ICP the category school or educational facility (C2) does not include sub-categories as done in the ICD. Kindergarten and university are given as illustrative examples in the ICP for category C2.

It is important to note that the scope of the ICP differs from the ICD. The unit of classification of the ICD is place of injury occurrence, which the ICP does not attempt to classify – in cases where injury leads to death, place of injury occurrence and place of death occurrence may differ. The scope and population in question in the ICP are also broader, as it covers not only external causes of death but all causes of death. Annex 3 provides a visual representation of the correspondence between ICP and ICD.

Implications for national statistical systems

Administrative data about deaths are registered and handled by authorities at a national and/or regional level, most commonly by statistical agencies, but also by health authorities and centers for epidemiology, hygiene and disease control (see details of the data providers of place of death data used in our studies in pages 2 and 3). Mortality data is also registered and handled by service providers from different sectors (e.g., health and social services, police, funeral agencies).

Statistical data from surveys add insight into the distribution of places of end of life care and places of death, the associated factors that explain variations, and discrepancies between preferred and actual dying places. Population-based mortality followback surveys that gather data from and about a representative sample of deceased individuals based on the accounts of bereaved relatives or care providers produce results that can be generalized to the entire population.[34-36] These can be conducted either as a dedicated survey or embedded as a module in a wider survey.

To improve such data by collecting information about dying places using the ICP, the above-named sectors and institutions will need to be involved. We have started doing so, by consulting a wide range of key stakeholders (including 18 statistical agencies, among other stakeholders) and discussing with them the implications for their routine practice. We found ample recognition of the need for standardization and of the value of the ICP as a global standard fit for purpose. National statistical agencies play a central role in coordinating efforts and harmonizing data.

Implementation and maintenance plans

The integration of the ICP at national and/or regional levels will be a gradual process that will consider the maturity of data collection systems in each country and/or region, the timing of planned changes, and adaptations in laws and regulations where required. National statistical agencies as well as health authorities and research organizations that collect information on dying places will be the primary implementers. It is anticipated that the ICP will be regularly updated, based on implementation uptake, challenges, successes and lessons learnt.

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Annexes

Annex 1: Draft ICP
Annex 2: ICP alphabetical index
Annex 3: Correspondence with the ICD

ICP
International Classification of Dying Places

DRAFT VERSION
Confidential - do not circulate

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EOL IN PLACE

European Research Council

1 2 9 0 UNIVERSIDADE D COIMBRA

CHAPTER 1. DWELLING OR DOMICILE **A**

Incl: place of residence, where people live in
Excl: health or care facility (chapter 2)

A1. INDIVIDUAL
Incl: private residence including house, flat and others (e.g., caravan, houseboat, hut, etc.)

A11 own (rented or owned by the person or parents/custodians for minors)
A12 of others (specify, e.g., of family member, friend, etc.)
A13 ownership unknown

A2. CONGREGATE
Incl: collective residence of communal nature where a group of persons reside
Excl: collective residence of communal nature with health or care provision, e.g., assisted living community (chapter 2)

A21 prison or correctional facility (e.g., prison, penitentiary)
A22 religious space or institution (e.g., convent, monastery)
A23 camp for refugees and internally displaced persons
A24 military facility
A25 independent living community or retirement home without health or care provision
A26 other (specify, e.g., workers´ camp, student dormitory, homeless shelter, etc.)
A27 type unknown

A3. OTHER
(specify, e.g., street for homeless person who lives/lived on the street)

A qualifiers:
Is/was this place regarded by the person as their home? Y/N/DK
Is/was this place the person's workplace or school? Y/N/DK

Incl.: place where people go or stay to receive care (health-related or other)
Excl.: congregate dwelling or domicile without health or care provision (A2), other facility (chapter 3)

B1. HOSPITAL
Incl: facility that provides mostly acute care (medical, nursing and/or other)
Excl: long-term care facility or nursing home (B2), palliative care facility or hospice (B3) and primary care facility (B4)

B11 emergency department
B12 intensive care unit
B13 long-term care unit within hospital
B14 palliative care unit or hospice within hospital
B15 internal medicine unit
B16 surgical unit
B17 other inpatient unit (specify)
B18 outpatient clinic (specify)
B19 other (specify)
B20 unknown

B2. LONG-TERM CARE FACILITY OR NURSING HOME
Incl.: facility that provides long-term care, including inpatient or outpatient rehabilitation, skilled nursing care. Includes assisted living community, retirement home and day centre with health or care provision.
Excl.: hospice or palliative care facility (B3), long-term care unit within hospital (B13)

B21 palliative care unit or hospice within long-term care facility or nursing home
B22 other (specify)
B23 unknown

B3. PALLIATIVE CARE FACILITY OR HOSPICE FACILITY
Incl.: facility that provides care specifically for people with advanced diseases
Excl: palliative care unit or hospice within hospital (B14)

B4. PRIMARY CARE FACILITY OR COMMUNITY HEALTH CENTRE
Incl.: primary care, community health or family medicine centre, practice, clinic or office

B5. OTHER (SPECIFY)

B qualifiers
Is/was this place regarded by the person as their home? Y/N/DK
Is/was this place the person's workplace or school? Y/N/DK
Maternity or obstetrics facility or unit? Y/N/DK
Pediatric facility or unit? Y/N/DK
Psychiatric or mental health facility or unit? Y/N/DK
Corridor or waiting area? Y/N/DK
Mobile, temporary or permanent facility? M/T/P/DK

CHAPTER 3. OTHER FACILITY

C

Incl.: place where people go or stay but not to receive care
Excl.: when the facility is the person's place of residence code A2 (e.g., when person lives in religious space for example a shrine, code A22), health or care facility (chapter 2)

C1. Sport and athletics facility (e.g., indoor sporting hall, skating rink)
C2. School or educational facility (e.g., kindergarten, university)
C3. Religious space or institution (e.g., church, shrine)
C4. Recreational or cultural facility (e.g., amusement park, museum)
C5. Non-recreational commercial facility (e.g., shop, café, restaurant)
C6. Transport facility (e.g., train station, airport; if within vehicle code in chapter 5)
C7. Hotel or lodging house (if for living code in chapter 1)
C8. Industrial or construction area (e.g., factory, mine)
C9. Farm or other place of primary production (e.g., plant cultivation, fishery)
C10. Other (specify)

C qualifiers:
Is/was this place the person's workplace or school? Y/N/DK

Incl.: open-air space
Excl.: open-air space within dwelling or domicile (chapter 1), within health or care facilities (chapter 2) or within other facilities (chapter 3);
when it is the person's place of residence (e.g., street for homeless person, code A3)

D1. Public highway, street or road
D2. Railway (if train station code C6)
D3. Water (sea, river, pool)
D4. Field, forest, mountain or desert
D5. Other (specify)

D qualifiers:
Is/was this place the person's workplace? Y/N/DK

Incl.: a means of transportation of things or people, with or without engine
Excl.: when the vehicle is the person's place of residence (e.g., caravan, code A1),
when the vehicle is a place where people go or stay to receive care (e.g., mobile clinic, code B4)

E1. Ambulance
E2. Motorcycle, scooter or bicycle
E3. Car, van or caravan
E4. Bus or minibus
E5. Train, tram or metro
E6. Trailer or tractor
E7. Plane, helicopter or other aircraft
E8. Other (specify)

E qualifiers:
Land, water or air vehicle? L/W/A/DK
During transport to or from health or care facility? Y/N/DK
Is/was this place the person's workplace? Y/N/DK

CHAPTER 6. OTHER

F

(Specify)

CHAPTER 7. UNKNOWN

G

ICP Alphabetical Index

Term	Code
Aircraft	E7
Airport	See C6
Ambulance	E1
Amusement park	See C4
Assisted living community	B2
Athletics facility	C1
Bicycle	E2
Bus	E4
Café	See C5
Camp for internally displaced persons or refugees	A23
Car	E3
Caravan	See A1 (included), E3
Care facility	B, See C (excluded)
Church	See C3
Clinic	B4, B18
Collective residence of communal nature	See A2 (included and excluded)
Commercial facility	C5
Community health centre, practice, clinic or office	B4
Congregate dwelling or domicile	A2, See B (excluded)
Convent	See A22
Construction area	C8
Correctional facility	A21
Corridor	See B qualifiers
Cultural facility	C4
Day centre	B2
Desert	D4
Domicile	A

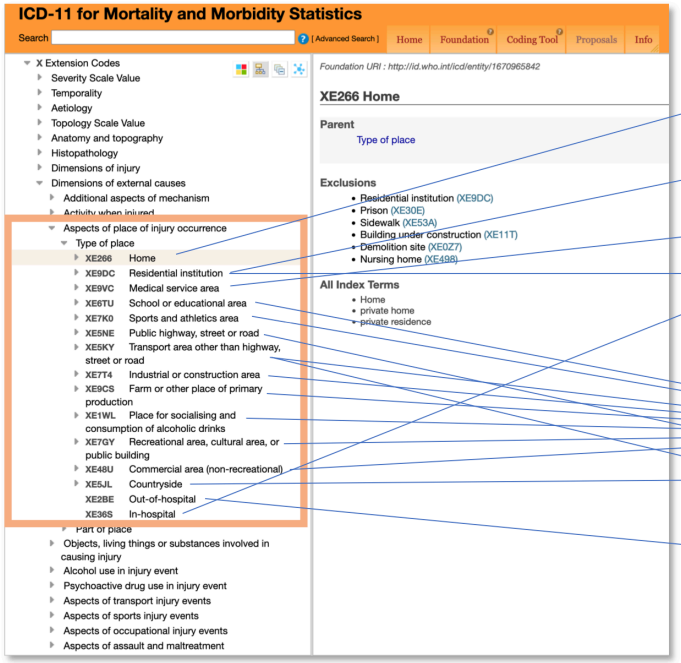
Dwelling	A
Educational facility	C2
Emergency department	B11
Factory	See C8
Family medicine centre, practice, clinic or office	See B4 (included)
Farm	C9
Field	D4
Fishery	See C9
Flat	See A1 (included)
Forest	D4
Health facility	B, See C (excluded)
Helicopter	E7
Highway	D1
Home (as regarded by person)	See A qualifiers, B qualifiers
Homeless shelter	See A26
Hospice	B14, B21, B3
Hotel	C7
House	See A1 (included)
Houseboat	A1
Hut	A1
Independent living community	A25
Individual dwelling or domicile	A, See D (excluded)
Indoor sporting hall	See C1
Industrial area	C8
Inpatient unit	B17
Intensive care unit	B12
Internal medicine unit	B15
Kindergarten	See C2
Long-term care facility	B2
Long-term care unit within hospital	B13
Medical unit	B15, B16, B17
Mental health facility	See B qualifiers
Metro	E5
Military facility	A24

Mine	See C8
Minibus	E4
Mobile facility or clinic	See B qualifiers, E (excluded)
Monastery	See A22
Motorcycle	E2
Mountain	D4
Museum	See C4
Non-recreational commercial facilities	C5
Nursing home	B2, See B1 (excluded)
Lodging house	C7
Office	B4
Open air space	See D (included and excluded)
Outdoor	D
Outpatient clinic	B18
Palliative care facility or unit	B3, B14, B21, See B3 (excluded)
Pediatric facility	See B qualifiers
Pediatric unit	See B qualifiers
Penitentiary	See A21
Permanent facility	See B qualifiers
Place of primary production	C9
Place of residence	See A (included), C, D and E (excluded)
Plane	E7
Plant cultivation	See C9
Pool	See D3
Practice	B4
Primary care facility, centre, practice, clinic or office	B4
Prison	See A21
Private residence	See A1 (included)
Psychiatric facility	See B qualifiers
Public highway	D1
Railway	D2
Recreational facility	C4
Religious institution	A22, C3

Religious space	A22, C3
Residence, private	See A1 (included)
Residence, collective	See A2 (included and excluded)
Restaurant	See C5
Retirement home	A25, See B2 (included)
River	See D3
Road	D1
School	C2, See A qualifiers, B qualifiers, C qualifiers
Scooter	E2
Sea	See D3
Shop	See C5
Shrine	See C3
Skating rink	See C1
Skilled nursing care	B2
Sport facility	C1
Street	See A3, See D (excluded), D1
Street for homeless person	See A3, See D (excluded)
Student dormitory	See A26
Surgical unit	B16
Temporary facility	See B qualifiers, E qualifiers
Tractor	E6
Trailer	E6
Train	E5
Train station	See C6, D2
Tram	E5
Transport facility	C6
University	See C2
Van	E3
Vehicle	E, See C6 (excluded)
Waiting area	See B qualifiers
Water	D3, See E qualifiers
Workers' camp	See A26
Workplace	See A qualifiers, B qualifiers, C qualifiers, D qualifiers, E qualifiers

Correspondence with the ICD
(visual representation)

International Classification of Diseases (ICD)



International Classification of Dying Places (ICP)

- ∇ **A** Dwelling or domicile
  - ∇ **A1** Individual
  - ∇ **A2** Congregate
  - **A3** Own (specify)
- ∇ **B** Health or care facility
  - ∇ **B1** Hospital
  - ∇ **B2** Long-term care facility or nursing home
  - **B3** Palliative care facility or hospice facility
  - **B4** Primary care facility or community health centre
  - **B5** Other (specify)
- ∇ **C** Other facility
- ∇ **D** Outdoor
- ∇ **E** In vehicle
- **F** Other (specify)
- **G** Unknown