



Department
of Health &
Social Care

Guidance

Guidance for medical practitioners completing medical certificates of cause of death in England and Wales

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Applies to England and Wales

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Definitions of medical practitioner and medical examiner

All references to 'medical practitioner' in this document mean a qualified medical practitioner who holds a valid registration from the General Medical Council (GMC) and a licence to practise, in accordance with the [Medical Act 1983](https://www.legislation.gov.uk/ukpga/1983/54/contents) (<https://www.legislation.gov.uk/ukpga/1983/54/contents>). A medical certificate of cause of death (MCCD) completed by a physician who does not have a current licence to practise at the time of completion would not be legally valid.

Under the [Coroners and Justice Act 2009](https://www.legislation.gov.uk/ukpga/2009/25/contents) (<https://www.legislation.gov.uk/ukpga/2009/25/contents>), the medical practitioner responsible for completing an MCCD is also referred to as the 'attending practitioner'. All references to 'medical examiner' refer to senior medical practitioners, as defined above, who are employed by an NHS body to provide independent scrutiny of the causes of death.

The purposes of death certification

Prompt and accurate completion of an MCCD is essential because it serves a number of functions. It enables the death to be registered, providing a permanent legal record of the fact of death and the medical cause of death. It allows the deceased person's representative to take steps to arrange disposal of the body and to begin the process of settling the deceased person's estate. By law, deaths must be registered within 5 days of receipt of the MCCD by the registrar unless there is to be a coroner's investigation.

After the death has been registered, the 'informant' can buy a certified copy of the register entry - the 'death certificate' - which includes an exact copy of the cause of death information described on the MCCD. This gives them information on how the person died, which may be important for their own health and that of future generations. The informant is someone who meets the legal criteria to register the death with the registrar. The informant is often a member of the deceased person's family.

Information from death registration, which includes information from the MCCD, is used to produce statistics on causes of death, mortality rates, life expectancy and other important measures. Statistical information on deaths by cause is important for:

- monitoring the health of the population
- surveillance of epidemics and pandemics

- designing and evaluating public health interventions
- recognising priorities for medical research and health services
- planning health services and assessing their effectiveness

Death registration data is extensively used in medical research and to understand the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.

Who should certify the cause of death

Any medical practitioner who has attended the deceased within their lifetime can complete an MCCD if they can establish the cause of death to the best of their knowledge and belief, and the death is not required to be notified to the coroner.

Although there is no legal definition of 'attended', it is generally accepted to mean a medical practitioner who has cared for the patient and who is familiar with the patient's medical history, investigations and treatments. The attending practitioner must also have access to relevant medical records and the results of investigations. It is a legal requirement for a medical practitioner - who meets the necessary criteria to complete the MCCD - to establish the cause of death and complete the MCCD. There is no provision under legislation to delegate this statutory duty to any non-medical staff.

There are 2 attending practitioner MCCDs:

- APC 1, which is for people dying after the first 28 days of life
- APC 2, which is for live-born children dying within the first 28 days of life

In hospital, there may be several medical practitioners in a team caring for the patient. In these settings, it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified and to agree the attending practitioner to certify the death. If the attending practitioner is unable to carry out their duties within a reasonable time, another attending practitioner must carry out those duties. Any subsequent enquiries, such as for the results of post-mortem or ante-mortem investigations, should be addressed by the relevant consultant.

In general practice, more than one GP may have been involved in the patient's care and so will be able to certify the death.

In any setting where MCCDs are completed, if a medical practitioner who attended the patient cannot be found within a reasonable time, the death must be referred to the coroner. Read more in the section on ‘referring deaths to the coroner.’

Role of the medical examiner

Medical examiners scrutinise the cause of death provided by the medical practitioner completing the MCCD. The statutory system of medical examiners was introduced on 9 September 2024, in response to the findings of numerous independent inquiries, including the Shipman Inquiry. All deaths not investigated by the coroner must receive appropriate scrutiny by a medical examiner.

In addition to scrutinising the cause of death, medical examiners will offer a conversation about the cause of death with the deceased’s representative, which provides an opportunity for them to raise concerns. This conversation can be carried out by the medical examiner officer. This is an important step in helping the bereaved to understand the cause of death and the sequence of conditions that led to it. For the attending practitioner, engaging the medical examiner as soon as possible to discuss their thinking on the cause of death can positively impact these subsequent conversations with the representative of the deceased and limit any potential delays to the death’s eventual registration.

Once the medical examiner has scrutinised the cause of death and signed the declaration, the medical examiner office will send the MCCD to the registrar for registration of the death. The medical examiner office will also inform the representative of the deceased that the MCCD has been transferred to the registrar for registration of the death without unreasonable delay.

You can read more about the role of medical examiners in the [National Medical Examiner’s guidance for England and Wales](https://www.england.nhs.uk/publication/national-medical-examiners-guidance-for-england-and-wales/) (<https://www.england.nhs.uk/publication/national-medical-examiners-guidance-for-england-and-wales/>), published by NHS England.

Referring deaths to the coroner

Under the [Notification of Deaths Regulations 2019](https://www.legislation.gov.uk/ukxi/2019/1112/made) (<https://www.legislation.gov.uk/ukxi/2019/1112/made>) medical practitioners have

a legal obligation to report cases to the coroner where there is reason to suspect that:

- the death was unnatural or violent
- the cause of death is unknown
- the death occurred in custody or other state detention

This can include cases where the death is due to the person undergoing a treatment or procedure of a medical or similar nature - for example, a death during an operation or before full recovery from an anaesthetic, where the cause was not natural. In addition, there will always be cases which may on one view be 'natural', but which have some other element (for example, concerns about neglect or standards of care) which brings them within the remit of the coroner. These must be reported to the coroner.

When a death is reported, it is for the coroner to decide whether their legal obligation to investigate is engaged. It is very important that the coroner is given all the facts relevant to this decision. The medical practitioner should discuss the case with the medical examiner before completing an MCCD if they are at all uncertain whether a referral to the coroner is required.

The coroner may decide that their duty to investigate does not arise, meaning that the death can be registered from the MCCD following scrutiny by the medical examiner. For example, deaths with fractured neck of femur mentioned on the MCCD are often referred to the coroner, but may not trigger the coroner's duty to investigate. Deaths which do not engage the coroner's duty to investigate will be sent back into the medical route for certification through the attending practitioner and medical examiner.

 **The medical practitioner will be in breach of their legal obligations if they omit to mention on the MCCD conditions or events that contributed to the death in order to avoid referral to the coroner.**

If the fact emerges after the death is registered, a coronial investigation may still be held.

In the majority of natural cause deaths, there will be a registered medical practitioner who is able to certify the death. However, if a medical practitioner who attended the patient and who meets the criteria to complete an MCCD cannot be found, the death must be referred by a registered medical practitioner to the coroner. If the coroner considers that the duty to investigate is not engaged there is provision for the coroner, exceptionally, to refer the death to the medical examiner to complete a medical examiner MCCD.

In the overwhelming majority of cases, there will be a medical practitioner who fulfils the criteria to provide a cause of death and so the number of cases which are referred by a coroner to a medical examiner for completion of the medical examiner's MCCD should be minimal.

Read more in the [guidance for medical practitioners on the Notification of Deaths Regulations 2019](https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance) (<https://www.gov.uk/government/publications/notification-of-deaths-regulations-2019-guidance>).

Completing the cause of death section: general advice

One of the main functions of the statutory medical examiner system is to scrutinise the causes of death and support the medical practitioner to arrive at the most accurate cause of death.

Outside the system of medical examiners, there remains increased scrutiny of death certification and patterns of mortality by local and national agencies as a result of the Shipman Inquiry. Suspicions may be raised if MCCDs appear to give inadequate or vague causes of death.

For example, if a patient dies under the care of an orthopaedic surgeon, it might be expected that some orthopaedic condition contributed to the death. If an orthopaedic condition does not appear in either part 1 or part 2 of the MCCD, this will likely be an area the medical examiner will discuss with the attending practitioner.

Similarly, it would be surprising if a patient was being treated in an acute hospital, but no significant disease or injury at all was mentioned on their MCCD.

The following sections provide guidance on how to complete the cause of death section.

Sequencing cause of death, underlying cause and contributory causes

On the non-neonatal MCCD, APC 1, the cause section of the MCCD is set out in 2 parts, in accordance with World Health Organization (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD).

Part 1

The attending practitioner is asked to start with the immediate, direct cause of death on line a of part 1. Having started with the immediate, direct cause of death you should go back through the sequence of events or conditions that led to death on subsequent lines (lines b to d) of part 1, until you reach the condition that started the fatal sequence.

If the MCCD has been completed properly, the condition on the lowest completed line of part 1 will have caused all of the conditions on the lines above it. This initiating condition, on the lowest completed line of part 1, will usually be selected as the underlying cause of death, following ICD coding rules.

WHO defines the underlying cause of death as: “a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury.”

From a public health point of view, preventing this first disease or injury will result in the greatest health gain. Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health services and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

Part 2

You should also enter any other diseases, injuries, conditions or events that contributed to the death, but were not part of the direct sequence, in part 2 of the MCCD. The conditions mentioned in part 2 must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time.

Duration

Wherever possible, you should provide the duration of each disease or condition, referred to as the ‘approximate interval between onset and death’ on the MCCDs, although the medical record may not always support this.

Medical examiners should strongly encourage completion of duration information. This is because complete duration information helps to ensure that the order of the sequence of conditions is accurate and affects mortality coding and the selection of underlying cause in some cases such as where there is a separate ICD code for ‘late effects’ or ‘sequelae’. It also provides additional information for medical research.

For example, it matters for underlying cause selection if a stroke occurred more than 12 months ago rather than more recently, as does a myocardial infarction being 28 days or more between onset of the condition and death.

The following examples illustrate how to handle common scenarios you may come across.

Example 1

The disease or condition thought to be the underlying cause of death should appear in the lowest completed line of part 1.

Part	Disease or condition	Duration
1a: disease or condition leading directly to death	Myocardial infarction	2 days
1b: other disease or condition, if any, leading to 1a	Ischaemic heart disease	5 years
1c: other disease or condition, if any, leading to 1b	Coronary artery atheroma	10 years
1d: other disease or condition, if any, leading to 1c	Hypercholesterolaemia and tobacco smoking	15 years
2: other significant conditions contributing to death but not related to the disease or condition causing it	Non-insulin dependent diabetes mellitus	20 years

Hypercholesterolaemia and tobacco smoking on line 1d is the underlying cause.

In subsequent examples, the layout of the MCCD has not been reproduced in full.

Example 2

The disease or condition thought to be the underlying cause of death should appear in the lowest completed line of part 1.

Part	Disease or condition	Duration
1a: disease or condition leading directly to death	Cerebral infarction	1 day
1b: other disease or condition, if any, leading to 1a	Thrombosis of basilar artery	2 days
1c: other disease or condition, if any, leading to 1b	Cerebrovascular atherosclerosis	6 months

The cerebrovascular atherosclerosis on line 1c is the underlying cause.

Other significant conditions contributing to death but not related to the disease or condition causing it: none given

Example 3: single disease

In some cases, a single disease may be wholly responsible for the death. In this case, it should be entered on line 1a.

Part	Disease or condition	Duration
1a	Meningococcal septicaemia	5 days

Meningococcal septicaemia is the underlying cause of this death.

Example 4: more than 4 conditions in the sequence

The MCCD in use in England and Wales has 4 lines in part 1 for the sequence leading directly to death. If you want to include more than 4 steps in the sequence, you can do so by writing more than one condition on a line, indicating clearly that one is due to, follows from, or is secondary to, the next.

Part	Disease or condition	Duration
1a	Sepsis	1 day
1b	Faecal peritonitis	2 days
1c	Perforation of the sigmoid colon	2 days
1d	Adhesions following previous right hemicolectomy for adenocarcinoma of the caecum	5 years

Adhesions following previous right hemicolectomy for adenocarcinoma of the caecum is the underlying cause.

Example 5: more than one disease may have led to death

If you know that your patient had more than one disease or condition that was compatible with the way in which they died, but you cannot say which was the most likely cause of death, you should include them all on the MCCD.

They should be written on the same line separated by the word 'and' or a comma. You can indicate that you think they contributed equally by writing 'joint causes of death' in brackets.

Part	Disease or condition	Duration
1a	Cardiorespiratory failure	5 days
1b	Ischaemic heart disease and chronic obstructive airways disease (joint causes of death)	2 years
2	Osteoarthritis	6 years

Or

Part	Disease or condition	Duration
1a	Hepatic failure	1 week
1b	Liver cirrhosis	6 months
1c	Chronic hepatitis C infection and chronic alcohol use (joint causes of death)	2 years

Where more than one condition is given on the lowest used line of part 1 as joint causes (that is, separated by the word 'and' or a comma rather than by the words 'due to' because the fifth condition led to the fourth), then the Office for National Statistics (ONS) will use the ICD coding rules to select the underlying cause for routine mortality statistics.

However, bear in mind, while there might be mortality coding rules that will mean one of the 2 conditions takes precedence over the other to become the underlying cause in statistics, where there are no such rules pertaining to that pair of conditions and the pair appear on the lowest line, the default coding approach will be that the underlying cause becomes the second of the 2 conditions on that line.

ONS also codes all of the conditions mentioned on the MCCD, not just the underlying cause (these other codes are referred to as 'mentions'). This multiple cause of death data is used by ONS in a variety of routine and ad hoc analyses and can be made available for research in some circumstances.

Avoid 'old age' alone

Old age, 'senility' or 'frailty of old age' should only be given as the sole cause of death where all the following circumstances apply:

- the deceased was over 80 years old
- you have personally cared for the deceased over a long period - this is difficult to define, but we would suggest at least several months
- you have observed a gradual decline in your patient's general health and functioning
- you are not aware of any identifiable disease or injury that contributed to the death
- you are certain that there is no reason that the death should be reported to the coroner

You may mention old age or frailty as a contributory cause, especially if it explains the severe effect of a condition that is not usually fatal.

You should also be aware that the representative of the deceased may not regard old age as an adequate explanation for the death and may request further investigation.

It is unlikely that patients would be admitted to an acute hospital if they had no apparent disease or injury. It follows that deaths in acute hospitals are unlikely to fulfil the conditions above. You can specify old age as a cause of death, but you should also mention in part 1 or part 2, as appropriate, any medical or surgical conditions that may have contributed to the death.

Example 6

Part	Disease or condition	Duration
1a	Pathological fractures of femoral neck and thoracic vertebrae	1 day
1b	Severe osteoporosis	10 years
1c	Old age	
2	Fibrosing alveolitis	15 years

Or

Part	Disease or condition	Duration
1a	Old age	
2	Non-insulin dependent diabetes mellitus, essential hypertension and diverticular disease	5 years

While there is no statutory age limit or restriction on referring to 'old age', a death certified as due to old age or senility alone will usually be referred to the coroner unless all the conditions listed above are fulfilled and there is no other reason that the death should be referred. Similar terms, such as 'frailty of old age', will be treated in the same way.

Never use 'natural causes' alone

The term 'natural causes' alone, with no specification of any disease on an MCCD, is not sufficient to allow the death to be registered without referral to the coroner. If you do not have any idea what disease caused the patient's death, it is up to the coroner to decide what investigations may be needed.

Avoid organ failure alone

Do not certify deaths as due to the failure of any organ without specifying the disease or condition that led to the organ failure. Failure of most organs can be due to unnatural causes, such as poisoning, injury or industrial disease. This means that the death will have to be referred to the coroner if no natural disease responsible for organ failure is specified.

Example 7

Part	Disease or condition	Duration
1a	Renal failure	1 week
1b	Lupus nephritis	3 weeks
1c	Systemic lupus erythematosus	10 years

Conditions such as renal failure may come to medical attention for the first time in frail, elderly patients in whom vigorous investigation and treatment may be contraindicated, even though the cause is not known. When such a patient dies, you are advised to discuss the case with the medical examiner in the first instance before certifying.

If the coroner is satisfied that no further investigation is warranted, the MCCD can then be completed and signed off by the medical examiner. The only exception is heart failure, which is acceptable on its own, but as ever, the underlying cause should be stated where known.

Avoid conditions that are not fatal in themselves

Long-term physical disabilities, mental health problems and learning disabilities (also known as intellectual disabilities) are rarely sufficient medical explanation of the death in themselves. If such a condition is considered to be relevant, the more immediate mechanisms or train of events leading to death must be made clear.

A description such as 'learning disabilities' should never be the cause of death.

You may give a degenerative condition such as Alzheimer's disease as the only cause of death if the mechanism by which it caused death is unclear, but it is fully supported by the clinical history as the underlying cause.

Some genetic conditions may be life limiting in and of themselves and these may therefore be reasonable to add to part 1 of the MCCD in lines 1b or 1c in some instances.

A description of 'learning difficulties' should never be used as a cause of death. A learning difficulty is a condition such as dyslexia which would not be a cause of death.

Avoid terminal events, modes of dying and other vague terms

Terms that do not identify a disease or pathological process clearly are not acceptable as the only cause of death. This includes terminal events, or modes of dying such as cardiac or respiratory arrest, syncope or shock.

Vague statements such as cardiovascular event or incident, debility or frailty are equally unacceptable. 'Cardiovascular event' could be intended to mean a stroke or myocardial infarction. It could, however, also include cardiac arrest or fainting, or a surgical or radiological procedure. If no clear disease can be identified as the cause of death after discussion with a medical examiner, referral to the coroner will be necessary.

Never use abbreviations or symbols

Do not use abbreviations on MCCDs. Their meaning may seem obvious to you in the context of your patient and their medical history, but it may not be clear to others. For example:

- does a death from ‘MI’ refer to myocardial infarction or mitral incompetence?
- is ‘RTI’ a respiratory or reproductive tract infection, or a road traffic incident?

The medical examiner should not accept an MCCD that includes any abbreviations. The same applies to medical symbols.

Neonatal deaths

The layout of the MCCD for a live-born child dying within the first 28 days of life is different from the non-neonatal MCCD. It provides space for both the infant’s and mother’s conditions.

It starts with the main disease or condition affecting the infant (line a), followed by other diseases or conditions affecting the infant (line b).

Line c is for the main maternal disease or condition affecting the infant and line d is for other maternal diseases or conditions affecting the infant. Line e is for other relevant factors or circumstances.

Example 8

This example shows the baby’s condition on line a and the mother’s condition on line c.

Part	Disease or condition
a: main disease or condition in infant	Intrapartum asphyxia
c: main maternal disease or condition affecting the infant	Placental pathology, maternal vascular malperfusion

Example 9

This shows the baby’s main condition on line a and multiple additional conditions on line b. No maternal conditions are listed and line e is completed.

Part	Disease or condition
a: main disease or condition in infant	Trisomy 13
b: other diseases or conditions in infant	Complex congenital heart disease, pulmonary atresia, ventricular septal defect
e: other relevant factors or circumstances (not diseases of infant or mother)	Cutis aplasia with absent skull vault

Completing the cause of death section: advice on specific causes

Stroke and cerebrovascular disorders

Give as much detail about the nature and site of the lesion as is available to you. For example, specify whether the cause was haemorrhage, thrombosis or embolism, and the specific artery involved, if known. Remember to consider any antecedent conditions or treatments, such as atrial fibrillation, artificial heart valves or anticoagulants that may have led to cerebral emboli or haemorrhage.

Avoid the term 'cerebrovascular accident' and consider using terms such as 'stroke' or 'cerebral infarction' if no more specific description can be given.

Example 10

Part	Disease or condition	Duration
1a	Subarachnoid haemorrhage	1 week
1b	Ruptured aneurysm of anterior communicating artery	1 week

Or

Part	Disease or condition	Duration
1a	Malignant middle cerebral artery syndrome	1 week
1b	Thromboembolic occlusion of the left middle cerebral artery	1 week
1c	Atrial fibrillation	1 year

Neoplasms

Malignant neoplasms (cancers) are a major cause of death. Accurate statistics are important for planning care and assessing the effects of changes in policy or practice. Where applicable, you should indicate whether a neoplasm was benign, malignant or of uncertain behaviour. Remember to specify the histological type and anatomical site of the cancer, and keep in mind that 'carcinoma' and 'cancer' are not synonyms.

Example 11

Part	Disease or condition	Duration
1a	Carcinomatosis	3 months
1b	Small cell carcinoma of left main bronchus	2 years
1c	Cigarette smoking	40 years
2	Hypertension, cerebral arteriosclerosis, ischaemic heart disease	10 years

You should make sure that there is no ambiguity about the primary site if both primary and secondary cancer sites are mentioned. Do not use the terms 'metastatic' or 'metastases' unless it is clear whether you mean metastases to, or metastases from, the named site.

Part	Disease or condition	Duration
1a	Intraperitoneal haemorrhage	1 day
1b	Metastases in liver	4 months
1c	From primary adenocarcinoma of ascending colon	8 months

Part	Disease or condition	Duration
2	Non-insulin dependent diabetes mellitus	6 years

Or

Part	Disease or condition	Duration
1a	Pathological fractures of left shoulder, spine and shaft of right femur	1 week
1b	Widespread skeletal metastases	5 months
1c	Primary invasive ductal carcinoma of breast	2 years
2	Hypercalcaemia	1 year

Or

Part	Disease or condition	Duration
1a	Lung metastases	6 months
1b	From testicular teratoma	2 years

If you mention 2 sites that are independent primary malignant neoplasms, make that clear.

Example 12

Part	Disease or condition	Duration
1a	Massive haemoptysis	1 day
1b	Primary small cell carcinoma of left main bronchus	6 months
2	Primary adenocarcinoma of prostate	1 year

If a patient has widespread metastases, but the primary site could not be determined, you should state this clearly.

Part	Disease or condition	Duration
1a	Multiple organ failure	1 day
1b	Poorly differentiated metastases throughout abdominal cavity	6 months
1c	Malignancy of unknown primary site	1 year

In the case of leukaemia, specify whether it is acute, sub-acute or chronic, and the cell type involved.

Example 13

Part	Disease or condition	Duration
1a	Neutropenic sepsis	2 days
1b	Acute myeloid leukaemia	6 months

Or

Part	Disease or condition	Duration
1a	Haemorrhagic gastritis	4 days
1b	Chronic lymphocytic leukaemia	2 years
2	Myocardial ischaemia, valvular heart disease	5 years

Diabetes mellitus

Always remember to specify whether your patient's diabetes was type 1 or type 2. If diabetes is the underlying cause of death, specify the complication or consequence that led to death, such as ketoacidosis.

Example 14

Part	Disease or condition	Duration
1a	End-stage renal failure	3 months
1b	Diabetic nephropathy	6 years

Part	Disease or condition	Duration
1c	Type 1 diabetes mellitus	30 years

Or

Part	Disease or condition	Duration
1a	Septicaemia - fully sensitive <i>Staphylococcus aureus</i>	5 days
1b	Gangrene of both feet	10 days
1c	Peripheral vascular disease	5 years
1d	Type 2 diabetes mellitus	7 years
2	Ischaemic heart disease	10 years

Deaths involving infections and communicable diseases

Mortality data is important in the surveillance of infectious diseases, as well as monitoring the effectiveness of immunisation and other prevention programmes. If the patient's death involved a notifiable disease, you have a statutory duty to notify the proper officer for the area, unless the case has already been notified. This is normally a consultant in communicable disease control (CCDC) in your local health protection team (HPT).

If you're not sure whether a case is notifiable, you can get advice from your local HPT who will also advise on appropriate microbiological investigations.

[Further information about notification of infectious diseases](https://www.gov.uk/government/collections/notifications-of-infectious-diseases-noids) (<https://www.gov.uk/government/collections/notifications-of-infectious-diseases-noids>) is available from the UK Health Security Agency.

In deaths from infectious disease, you should state the manifestation or body site, for example pneumonia, pyelonephritis, hepatitis, meningitis, septicaemia or wound infection. You should also specify, giving as much detail as is available:

- the infecting organism, such as pneumococcus, influenza A virus, meningococcus

- antibiotic resistance, if relevant, for example methicillin-resistant *Staphylococcus aureus*, or multiple drug resistant *Mycobacterium tuberculosis*
- the source and/or route of infection, if known, such as food poisoning, needle sharing, contaminated blood products, post-operative, community or hospital acquired, or healthcare-associated infection

COVID-19

If you are aware that a virology test for COVID-19 has been carried out, state the result if known, for example 'COVID-19 (positive test)'. However, you should not delay certification to wait for test results.

Example 15

Part	Disease or condition	Duration
1a	Bilateral pneumothoraces	2 days
1b	Multiple bronchopulmonary fistulae	5 days
1c	Extensive, cavitating pulmonary tuberculosis (smear and culture positive)	6 months
2	Iron deficiency anaemia; ventilator-associated <i>Pseudomonas aeruginosa</i>	1 year

You do not need to delay completing the certificate until laboratory results are available, provided you are satisfied that the death need not be referred to the coroner.

Failure to specify the infecting organism can lead to unnecessary investigation. For example, deaths are sometimes certified as being due to spinal or paraspinal abscess, without stating the organisms involved. These are then coded as tuberculosis following the ICD index and rules, which can lead to unnecessary efforts by the local CCDC to investigate the case.

Remember to specify any underlying disease that may have suppressed the patient's immunity or made them more susceptible to the infection that led to the death. Part 2 is likely to be the correct place to note this.

Healthcare-associated infections

It is a matter for your clinical judgement whether a condition the patient had at death, or in the preceding period, contributed to their death, and so whether it should be included on the MCCD. However, representatives of

the deceased may be surprised if you do not include something that they believe contributed to the death.

ONS receives frequent queries about mortality related to healthcare-associated infections, and complaints about the quality of information given on death certificates. Where infection does follow treatment, including surgery, radiotherapy, antineoplastic, immunosuppressive, antibiotic or other drug treatment for another disease, remember to specify the treatment and the disease for which it was given.

If a healthcare-associated infection was part of the sequence leading to death, it should be in part 1 of the MCCD, and you should include all the conditions in the sequence of events back to the original disease being treated.

Example 16

Part	Disease or condition	Duration
1a	Clostridium difficile pseudomembranous colitis	1 week
1b	Multiple antibiotic therapy	2 weeks
1c	Community acquired pneumonia with severe sepsis	2 weeks
2	Immobility, polymyalgia rheumatica, osteoporosis	2 years

Or

Part	Disease or condition	Duration
1a	Bronchopneumonia (hospital-acquired methicillin resistant Staphylococcus aureus)	4 days
1b	Multiple myeloma	6 months
2	Chronic obstructive airways disease	12 years

If your patient had a healthcare-associated infection which was not part of the direct sequence, but which you think contributed at all to their death, it should be mentioned in part 2.

Example 17

Part	Disease or condition	Duration
1a	Carcinomatosis and renal failure (joint causes of death)	3 months

Part	Disease or condition	Duration
1b	Adenocarcinoma of the prostate	2 years
2	Chronic obstructive airways disease and catheter-associated Escherichia coli urinary tract infection	5 years

Pneumonia

Pneumonia may present in previously fit adults, but often it occurs as a complication of another disease affecting the lungs, mobility, immunity or swallowing. Pneumonia may also follow other infections and may be associated with treatment for disease, injury or poisoning, especially when ventilatory assistance is required. Remember to specify, where possible, whether it was lobar or bronchopneumonia and whether primarily hypostatic or related to aspiration and the organism involved.

You should include the whole sequence of conditions and events leading up to it. If known, specify whether the pneumonia was hospital or community associated. If it was associated with mechanical ventilation, or invasive treatment, this should be clearly stated.

Example 18

Part	Disease or condition	Duration
1a	Hospital-associated pneumococcal pneumonia	1 week
1b	Influenza A	2 weeks
2	Alzheimer's disease	5 years

If you report bronchopneumonia, remember to include in the sequence in part 2 any predisposing conditions, especially those that may have led to paralysis, immobility, depressed immunity or wasting, as well as chronic respiratory conditions such as chronic bronchitis.

Example 19

Part	Disease or condition	Duration
1a	Bronchopneumonia	4 days
1b	Immobility and wasting	3 months

Part	Disease or condition	Duration
1c	Alzheimer's disease	7 years

Injuries and external causes

All deaths involving any form of injury or poisoning must be referred to the coroner. If the death is not one that must be investigated by the coroner and they instruct you to certify, remember to include details of how the injury occurred and where it happened, such as at home, in the street or at work.

Example 20

Part	Disease or condition	Duration
1a	Pulmonary embolism	2 days
1b	Fractured neck of femur	5 days
1c	Fall at home	5 days
2	Left-sided weakness and difficulty with balance since haemorrhagic stroke 5 years ago; hemiarthroplasty 2 days after fracture	5 years

Remember to state clearly if a fracture was pathological, that is due to an underlying disease process such as a metastasis from a malignant neoplasm or osteoporosis.

Substance misuse

Deaths from diseases related to chronic alcohol or tobacco use need not be referred to the coroner, provided the disease is clearly stated on the MCCD.

Example 21

Part	Disease or condition	Duration
1a	Carcinomatosis	6 months
1b	Bronchogenic carcinoma upper lobe left lung	2 years

Part	Disease or condition	Duration
1c	Smoked 30 cigarettes a day	40 years
2	Chronic bronchitis and ischaemic heart disease	4 years

Or

Part	Disease or condition	Duration
1a	Hepatic encephalopathy	3 weeks
1b	Alcohol-related liver cirrhosis	2 years
2	Difficult-to-control insulin-dependent diabetes	4 years

Deaths due to acute or chronic poisoning by any substance must be referred to the coroner.

Deaths involving drug dependence or misuse of substances other than alcohol and tobacco must be referred to the coroner. This does not mean that deaths where alcohol or tobacco are involved should never be referred.

Completing other sections

Many of the fields on the MCCD are self-explanatory, such as name of deceased, date of birth and NHS number. However, some of the fields may be less clear to the attending practitioner and this section should provide greater clarity on the purpose of those fields and how to complete them.

Place of death

‘Place of death’ is the address where the deceased person died. Often this will be the address of a hospital, hospice or residence.

In circumstances where the death occurred outside a recognised address (and which did not trigger the coroner’s duty to investigate) the attending practitioner should include the best available information. For example, where the death occurred in St James’s Park, the attending practitioner would write ‘St James’s Park.’

Post-mortem and coroner information

The coroner's duty to investigate is engaged where it is suspected that the deceased person died a violent or unnatural death, that the cause of death is unknown, or that the deceased died while in custody or otherwise in state detention. For such deaths, the coroner investigates and an MCCD is not required.

If the coroner reviews the death but decides not to investigate, select option 4: 'This death was reported to the coroner whose duty to investigate under S1 CJA2009 was not engaged.'

Maternal death questions

There are 2 questions relating to maternal deaths in the non-neonatal MCCD (APC 1):

1. was the deceased pregnant within the year prior to their death?
2. if the deceased was pregnant within the year prior to their death, did the pregnancy contribute to their death?

Each question lists multiple choice answers. For the first question the available answers are:

- 0. Not applicable
- 1. Pregnant at the time of death
- 2. Pregnant 1 to 42 days before death
- 3. Pregnant 43 days to a year before death
- 4. Not pregnant
- 9. Unknown

The use of '0. Not applicable' is for the deaths of those that the attending practitioner deems incapable of being pregnant. The use of '4. Not pregnant', is for the deaths where the attending practitioner believes the deceased was capable of being pregnant, but they were not at the time of death.

This will be subjective in many cases, especially in terms of age and with regards to other medical conditions impacting on fertility.

If in doubt, then select '4. Not pregnant'. The inclusion of 'not applicable' was intended for clear-cut cases where the selection of 'not pregnant' may have otherwise felt inappropriate.

You only need to answer the second question if option 1, 2 or 3 is selected for the first question. For the second question, the available answers are:

- 1. Yes
- 2. No
- 9. Unknown

Employment

The employment section asks whether the death may have been due to, or contributed to, by the employment followed at some point by the deceased.

You should select 'yes' if you believe that the employment followed at some point during the deceased person's lifetime could have influenced the cause of death. Examples could include respiratory diseases in a person who had been a miner during their working life.

Ethnicity

The categories used for the ethnicity question correspond to those used for the 2011 census. The attending practitioner should record the ethnicity of the deceased as it is recorded in the patient record. The attending practitioner should never guess the ethnicity of the deceased.

Select '19. Not known' if:

- there is no match with the listed categories
- there is no ethnicity recorded

Do not ask the representative of the deceased to confirm the ethnicity.

Implantable medical devices

The information on the MCCD about implantable medical devices will be transferred to the certificate for burial or cremation (the green form). The attending practitioner must indicate if they believe a hazardous implantable medical device is inside the body. Not providing this information represents a risk to cremation equipment and staff and can lead to delays to funerals.

The MCCD refers to 'implantable medical devices'. However, you only need to state whether there is a hazardous implantable medical device in the body of the deceased person, and if so, the type of device and whether it has been removed.

! Hazardous implants may damage cremation equipment and/or cause harm to crematorium staff if not removed from the body of the deceased before cremation. Some radioactive treatments may also endanger the health of crematorium staff.

For burials, hazardous implants may have environmental impacts which the burial authority may wish to consider.

Previously, the medical practitioner provided information relating to hazardous medical devices on the medical form used to release a body for cremation (Cremation 4). This form was removed on 9 September 2024, but the medical practitioner should provide the same information on the MCCD as under the previous system.

Non-exhaustive list of potentially hazardous implantable medical devices

Implants that could cause issues during a cremation include but are not limited to:

- pacemakers
- implantable cardioverter defibrillators
- cardiac resynchronization therapy devices (CRTDs)
- implantable loop recorders
- ventricular assist devices (VADs):
 - left ventricular assist devices (LVADs)
 - right ventricular assist devices (RVADs)
 - biventricular assist devices (BiVADs)
- implantable drug pumps including intrathecal pumps
- neurostimulators (including for pain and functional electrical stimulation)
- bone growth stimulators

- fixation nails
- any other battery powered or pressurised implant
- radioactive implants used to treat tumours, such as metal wires, seeds or tubes
- radiopharmaceutical treatment (via injection)

Qualifications

The attending practitioner must include their primary medical qualifications, as registered by the GMC, in the relevant field in the attending practitioner declaration box. 'MBBS' or similar is acceptable here and the field does not need to contain any additional qualifications or information.

MCCDs that do not contain the attending practitioner's qualifications cannot be used to register a death and will be returned to the attending practitioner.

Additional information for more precise statistical classification

Where applicable, circle '2. Information from post-mortem may be available later' on the MCCD. In these cases, there is no need to tick the box indicating that the attending practitioner may be in a position to give, on application by the Registrar General, additional information as to the cause of death for the purpose of more precise statistical classification.

Otherwise, where more information will be available later from tests where a post-mortem is not being held (for example, histological, microbiological or genetic tests), please indicate this by ticking this box.

Registrars will not follow up with a form requesting these details. However, ONS will use the information from this tick box to monitor the frequency with which such testing information is outstanding, and report this to users of the mortality data in accompanying user guides and metadata.