# Medical Certificate of Cause of Death (MCCD) – (Completion Of)

<table>
<thead>
<tr>
<th>Reference Number:</th>
<th>NHSCT/12/492</th>
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<tr>
<td>Target audience:</td>
<td>This applies to all medical staff who have responsibility for completing MCCDs.</td>
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</table>
| Sources of advice in relation to this document: | Barbara Bankhead, Trust Bereavement Co-Ordinator  
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Dr Peter Flanagan, Director of Medical Services |
| Replaces (if appropriate): | N/A |
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**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
Medical Certificate of Cause of Death (MCCD)
Clinicians’ Guide to Good Practice in Completion

A webpage on Death and Bereavement will be set up in due course under Business Areas on Staffnet. This will contain relevant documents and information to assist Trust staff in managing deaths.
Medical Certificate of Cause of Death (MCCD)
Clinicians’ Guide to Good Practice in Completion

1.0 Introduction

It is a statutory legal duty, based on Births and Deaths Registration (Northern Ireland) Order 1976, for Registered Medical Practitioners to provide a Medical Certificate of Cause of Death (MCCD) without delay if, to the best of their knowledge, that person died of natural causes for which they had treated them in the last 28 days.

All doctors completing MCCDs should be aware of when and how to complete the forms and when deaths should be referred to the Coroner.

2.0 Purpose

This guidance brings together information on legal requirements, good practice principles and local Trust algorithms for reference by medical staff.

3.0 Target Audience

This applies to all medical staff who have responsibility for completing MCCDs.

4.0 Responsibilities

4.1 The Medical Director is responsible for seeing that induction and update training on death certification and Coroners referrals is provided for relevant staff and for promoting good practice by monitoring or regular audit of death certification.

4.2 Clinical Directors are responsible for disseminating the guidance and promoting good practice on completion of MCCDs.

4.3 Doctors are responsible for adhering to the guidance. They should ensure they are competent to complete MCCDs by updating their knowledge as necessary.

5.0 Legislative Compliance/Policy Context

- Births and Deaths Registration (Northern Ireland) Order 1976
- Section 7 of the Coroners Act (Northern Ireland) 1959
- Guidance on Death, Stillbirth & Cremation Certification’ DHSSPS Ref 20/2008
- Verification of Life Extinct Policy NHSCT/09/129
- Procedure for Referring a Patient/Client’s Death to the Coroner (Adult Hospital Death Only) NHSCT/09/103

6.0 Equality, Human Rights and DDA

The policy is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

7.0 Alternative formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.
8.0 Sources of Advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

9.0 Completion of a Medical Certificate of Cause of Death (MCCD)

9.1 Registered Medical Practitioners have a legal duty to provide an MCCD without delay if, to the best of their knowledge, that person died of natural causes for which they had treated them in the last 28 days.

9.2 A doctor who had not been directly involved in the patient’s care at any time during the illness from which they died, cannot complete the MCCD.

9.3 All doctors completing MCCDs should be aware of when and how to complete the forms and when deaths should be referred to the Coroner (see Appendix 1). If a death is to be reported to the Coroner, an MCCD should not be issued.

9.4 Discussion of a case with a senior colleague may help clarify issues about completion of an MCCD or referral to the Coroner.

9.5 There may be several doctors in a team caring for the patient who will be able to complete the MCCD. In circumstances where the duty doctor is unable to complete the MCCD, they should check the patient’s medical records and ward duty rotas and record the name of the doctor who can do so, or arrange to speak to the consultant if necessary (see Appendix 2).

9.6 Doctors are expected to state the cause of death to the best of their knowledge and belief. It is ultimately the responsibility of the consultant in charge of the patient’s care to ensure that the death is properly certified and the content of the MCCD is discussed with relatives.

9.7 Completion of the MCCD:

- Ensure the form is readable (consider writing in BLOCK CAPITALS)
- Ensure patient details are entered correctly (i.e., name, address, place of death, date of death and also Health Service Number at the end of the form)
- Do not use abbreviations (the only abbreviations which the registrar can accept are HIV, AIDS and MRSA)
- Print name and GMC number beside signature
- Make a note in the patient’s medical records of the details recorded on the MCCD
- The counterfoil must be filed in the patient’s medical records
- Any alterations to the MCCD must be initialled by the doctor.

9.8 A body should not be released to the funeral director until the MCCD has been issued (or it is clearly recorded that the Coroner’s office has been contacted and a Post-Mortem Examination is not required). In order to accommodate the traditional timescales for burial in Northern Ireland, timely completion of the MCCD is required.

9.9 Registrars sometimes need to contact the doctor to clarify issues before registering the death. Difficulty in contacting the doctor can lead to delay in funeral arrangements and distress for relatives. Incorrectly completed forms can cause difficulties for the doctor, registrar and the relatives therefore every effort should be made to ensure accuracy.

9.10 If the patient had clostridium difficile or MRSA infection prior to their death then the procedures outlined in Appendix 3 and 4 should be followed.
Appendix 1

Deaths That Must Be Reported To The Coroner

There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death.

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

- as a result of violence, misadventure or by unfair means
- as a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged)

- from any cause other than natural illness or disease e.g.
  - homicidal deaths or deaths following assault
  - road traffic accidents or accidents at work
  - deaths associated with the misuse of drugs (whether accidental or deliberate)
  - any apparently suicidal death
  - all deaths from industrial diseases e.g. asbestosis

- from natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death

- death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do)

- in any circumstances that require investigation;
  - the death, although apparently natural, was unexpected
  - Sudden Unexpected Death in Infancy (SUDI)

- doctors should refer to the Registrar General’s extra-statutory list of causes of death that are referable to the coroner – see pages 8 – 14 ‘Guidance on Death, Stillbirth and Cremation Certification’, DHSSPS 2008.

When a death is referred to the Coroner, the Trust form ‘Referral of Death to Coroner’ should be completed and distributed as indicated on the bottom of the form. Triplicate books are available in wards and departments and should be used for this purpose (see NHSCFT Procedure for Referring a Patient/Client’s Death to the Coroner [Adult Hospital Death Only]).
Appendix 2
GUIDANCE FOR ISSUE OF THE MEDICAL CERTIFICATE OF CAUSE OF DEATH (MCCD) IN HOSPITAL
Refer to Guidance on Death, Stillbirth and Cremation Certification (DHSSPS Aug 2008) for further information

Death has occurred

Death verified and Life Extinct Record Sheet completed (by doctor or nurse trained in verification)

Doctor on duty is trained in death certification, has treated patient within 28 days and can write MCCD.

Doctor is foundation level and has not received training in death certification, or has not treated the patient in past 28 days, or needs to discuss the cause of death with consultant.

Doctor needs to discuss case with consultant for advice regarding possible referral to the Coroner.

Body removed to mortuary.
Death Certificate issued.
Mortuary Technician informed.

Body removed to mortuary.

Body may be removed to the mortuary if no suspicious circumstances.

• Doctor checks patient’s medical records and duty rotas and records the name of the Doctor who can write the MCCD or arranges to speak to consultant, if necessary.
• If the patient dies at night, MCCD to be signed the following morning and by 2.00 pm (unless in exceptional circumstances).
• If MCCD not signed by 12.00 midday, ward manager contacts Doctor to remind him/her.
• If MCCD not signed by 2.00 pm, consultant contacted.
• Any circumstances for delay in issue of MCCD should be recorded and family and Mortuary Technician kept informed.

Death Certificate issued. Mortuary Technician informed.

Body released to Funeral Director.

Body released to Funeral Director.

NB - A patient who has died should not be transferred to the mortuary before death has been verified by a staff member who is trained in Death Verification.
- A patient’s body should not be released to the Funeral Director before the MCCD has been issued or it is clearly recorded that the Coroner’s office has been contacted and a Post Mortem is not required.
- However, in community hospitals, following expected death, the GP may choose to give verbal authorisation for the release of the body prior to issuing the MCCD. This authorisation must be recorded in the patient’s records.
Patient dies in hospital.

Is the patient c diff toxin positive or has the patient had CDAD in the last 4 weeks?

No

Issue death certificate in usual way.

Yes

Doctor certifying death consults senior medical colleague to advise if C.Diff contributed to death and should be included in death certificate.

No it did not contribute.

Certifying doctor asks ward clerk to copy death certificate to Dr Flanagan with a note as to why C.Diff was not a contributory factor.

Certifying doctor/consultant discusses rationale for causes of death on death certificate with family. Counterfoil of death certificate filed in patient’s chart on ward.

Yes it did contribute.

Certifying doctor asks ward clerk to email Medical Director to say c diff death has occurred in ward x and post copy of death certificate to Medical Director.

Medical Director’s secretary adds details from death certificates to her database for Medical Director to validate CSA data against weekly. In Medical Director’s absence he will designate a deputy to do this.

Medical Director briefs Chief Executive on deaths as appropriate.

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1 In the absence of Ward Clerk, Nurse in Charge will ensure that is done.
2 No confidential detail of patient identity to be included in e-mail.
Appendix 4

DEATH CERTIFICATION PROCEDURE FOR PATIENTS WHO HAVE MRSA

Patient dies in hospital.

Is the patient known to be colonised / infected with MRSA?

Yes

Is the patient known to have/had active MRSA infection, or a positive MRSA blood culture during the preceding 30 days?

Yes

No it did not contribute.

Doctor certifying death consults senior medical colleague to advise if MRSA contributed to death and should be included in death certificate.

Certifying doctor asks ward clerk to copy death certificate to Dr Flanagan with a note as to why MRSA was not a contributory factor.

Certifying doctor/consultant discusses rationale for causes of death on death certificate with family. Counterfoil of death certificate filed in patient’s chart on ward.

Certifying doctor asks ward clerk to email Medical Director to say MRSA death has occurred in ward x and post copy of death certificate to Medical Director.

Medical Director’s secretary adds details from death certificates to her database for Medical Director to validate CSA data against weekly.

Medical Director briefs Chief Executive on deaths as appropriate.

No

Issue death certificate in usual way.

No

Yes it did contribute.

Issue death certificate in usual way.

Yes

Is the patient known to be colonised / infected with MRSA?

No

Issue death certificate in usual way.

Yes it did contribute.

Certifying doctor asks ward clerk to email Medical Director to say MRSA death has occurred in ward x and post copy of death certificate to Medical Director.

Medical Director’s secretary adds details from death certificates to her database for Medical Director to validate CSA data against weekly.

Medical Director briefs Chief Executive on deaths as appropriate.

1 In the absence of Ward Clerk, Nurse in Charge will ensure that is done.

2 No confidential detail of patient identity to be included in e-mail.