Guidelines for Death Certification – Handwritten MCCD

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Steps and requirements needed when completing a handwritten MCCD

BEFORE
you proceed with completing a Medical Certificate of Cause of Death (MCCD), ask yourself this question,
“Should this Death be reported to the Coroner?”

Do not use the ‘Back’ button: Use Bookmarks.

Bookmarks
This guidance document has bookmarks available for navigation. If they have not appeared, access depends on which browser you are using:

For Internet Explorer: right click, select ‘Show the Navigation Pane’, click the icon on the left hand of the screen.

For Chrome: click the icon on the toolbar at the top-left of the screen.

For Microsoft Edge: (which is a new browser included as part of Windows 10), this browser does not currently support the use of bookmarks. Please use Internet Explorer.
INTRODUCTION

When someone dies, the death must be registered by the General Register Office for Northern Ireland (GRO). Before it can be registered, the Registrar must be provided with notification of the death and either a Medical Certificate of the Cause of Death (MCCD) from a doctor or authorisation from a Coroner. For most deaths, the doctor who attended and provided care within twenty-eight days of death completes the MCCD to the best of their knowledge and belief; a statutory requirement. This is delivered to the local Registrar who issues the formal Death Certificate and an authority for the disposal of the body (Form GRO21).

The purposes of Death Certification

Death Certification serves social, legal and health functions. It,

- allows completion of a permanent legal record of the fact of death in the form of the Death Certificate;
- enables the family to make funeral arrangements; and
- the Registrar can provide copies of the Death Certificate, enabling the family to settle the deceased’s estate.

This provides the family with an explanation of how and why their relative died. It also gives them a permanent record of information about their family medical history, which may be important for their own health and that of future generations.

In addition, the MCCD, provides the underlying cause of death which influences,

- population health monitoring;
- design and evaluation of public health interventions;
- recognition of priorities for medical research and health services;
- planning of health services; and
- assessment of the effectiveness of services.
WHO CAN COMPLETE THE MEDICAL CERTIFICATE OF CAUSE OF DEATH?

Doctors certifying deaths do so as a statutory duty under the Births and Deaths Registration (Northern Ireland) Order 1976 Section 25(2) which holds that,

“Where any person dies as a result of any natural illness for which he has been treated by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified informant a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death, together with such other particulars as may be prescribed.”

MCCDs can only be completed by a registered medical practitioner who saw and treated the deceased during their last illness. No other person or practitioner may sign the certificate on his/her behalf. The completion of MCCDs is a statutory duty with doctors being subject to regulation of their conduct by the General Medical Council, rather than a condition of employment in the NHS. They must state the cause(s) of death to the best of their knowledge and belief and give the certificate forthwith\(^1\) to the Informant or report to the Coroner if necessary.

The General Medical Council guidance Treatment and care towards the end of life: July 2010, provides a framework for good practice when providing treatment and care for patients who are reaching the end of their lives. Section 85 states, “You must be professional and compassionate when confirming and pronouncing death and must follow the law, and statutory codes of practice, governing completion of death and cremation certificates. If it is your responsibility to sign a death or cremation certificate, you should do so without unnecessary delay. If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient’s wishes if they are known.”

In hospital, there may be several doctors in a team caring for the patient who will be able to certify the cause of death. It is ultimately the responsibility of the Consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete MCCDs unless they have received appropriate training. Discussion of a case with a senior colleague may help clarify issues about completion of an MCCD or referral to a Coroner.

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

A doctor, who had not been directly involved in the patient’s care at any time during the illness from which they died, cannot certify the cause of death, but they should provide the Coroner with any information that may help to determine the cause of death.

\(^1\) Definition of forthwith: In official use, forthwith means immediately; without delay.

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GOOD PRACTICE RULES FOR DEATH CERTIFICATION

The MCCD must be completed and signed by the doctor who saw and treated the deceased for their cause of death within 28 days of death.

The MCCD should be completed as soon as possible after death occurs and given to the Informant; the legislation indicates that this must be immediately, without delay, remembering that Registration should occur within 5 days of receiving the MCCD and before burial or cremation is performed.

It is not acceptable for a MCCD to be signed on behalf of someone else i.e. with the signature preceded by p.p. (per procurationem).

Doctors are expected to state the Cause of Death to the best of their knowledge and belief.

It is good practice to make a note of the details recorded on a handwritten MCCD in the patient clinical records.

All registered medical practitioners completing MCCDs should ensure they are competent by updating their knowledge and regularly reflecting on their practice.

- For further guidance and how to complete a handwritten MCCD, please view How to complete a Medical Certificate of Cause of Death - Handwritten.

Legibility and spelling

Ensure the handwritten MCCD form,

- is legible;
- has the correct spelling;
- uses BLOCK CAPITALS; and
- any alterations to the MCCD must be initialled by the doctor.

Abbreviations or symbols

The only abbreviations a Registrar can accept are,

- HIV for Human Immunodeficiency Virus infection;
- AIDS for Acquired Immune Deficiency Syndrome; and
- MRSA for Methicillin Resistant Staphylococcus Aureus.

Do not use other abbreviations on MCCDs. Their meaning may seem obvious to medical staff in the context of their work and their medical history, but it may not be clear to others and therefore may be a source of ambiguity causing potential delay to the registration process. Inappropriate use of abbreviations can result in the cause of death being recorded incorrectly on Death Certificates.

For example, using,

- MI instead of myocardial infarction. Does,
  - a death from “MI” refer to myocardial infarction or mitral incompetence?
- MS instead of multiple sclerosis. Does,
  - MS refer to multiple sclerosis, mitral stenosis or morphine sulphate?
- (L) instead of left;
- medical symbols such as 1° instead of primary; or
- # instead of fracture.
GMC guidance, registered name and reference number
There is GMC guidance on what registered doctors must do regarding the use of their registered name and GMC reference number.

http://www.gmc-uk.org/doctors/information_for_doctors/doctors_registration_number.asp

Registered name
This is your full name, as it appears in the Medical Register.

GMC reference number
This is the 7-digit number given when you first register with the GMC. Always use your own GMC number when completing a MCCD.

You must,
- be familiar with your GMC reference number;
- use your registered name when signing statutory documents; and
- make your registered name & GMC reference number available to anyone who asks.

Responsibility to the Family and Informant
Please note that once you have signed and dated the MCCD, best practice indicates that you should give it to a family member or next of kin, if one of them is available.

There is an expectation that you will explain the details contained within the Cause of Death section to family members of the deceased. See Treatment and care towards the end of life: General Medical Council, July 2010, Section 85.

“...... If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient’s wishes if they are known.”

Treatment and care towards the end of life: General Medical Council, July 2010

Signing the MCCD
The MCCD must be signed by the certifying medical practitioner. It is not acceptable for a MCCD to be signed on behalf of someone else i.e. with the signature preceded by p.p. (per procreationem).
A STEP-BY-STEP GUIDE TO COMPLETING A MCCD

Since November 2016, there have been 2 methods of completing and obtaining a Medical Certificate of Cause of Death (MCCD) in Northern Ireland.

1. **Using the Northern Ireland Electronic Care Record (NIECR).**
   This is now the standard method of recording a death and producing a MCCD in Health and Social Care (HSC) Trust hospitals. The MCCD is completed electronically on the NIECR producing an eMCCD, which then must be printed and signed – a printed eMCCD.

   If guidance is required on using the NIECR to print the eMCCD, click 👆 here.

2. **Completion of the handwritten MCCD.**
   A handwritten MCCD remains the method of recording a death and producing a MCCD in primary care, community hospitals, nursing homes, hospices, in the home and also as a contingency measure in HSC Trust hospitals when NIECR is non-functioning.

   This guidance refers to the handwritten MCCD.

A detailed and sequenced description of the steps and requirements needed when completing a handwritten MCCD are given 👆 here (& printed from 👆 here).

SELECTING THE CORRECT MCCD FORM

In 2012, as part of a Department of Health (DoH) review into the death certification process and taking into consideration the change by the GMC in 2009 to their regulation process, the General Register Office (GRO) for Northern Ireland amended the content and layout of the MCCD.

The revised MCCD now includes specific dedicated fields for the,
- Health and Care Number of the deceased;
- Coroner’s Reference Number (if appropriate);
- GMC Number of the certifying medical practitioner; and a
- section for a fully printed version of the certifying doctor’s name.

Please ensure you use one of the 2 MCCD forms shown below and it contains boxes to enter the,
- Health & Care number;
- GMC number; and
- Doctor’s printed name.
Any other older booklets, without dedicated fields for the H&C number, GMC number and printed name, which are still in use, must be destroyed.

A handwritten MCCD must only be completed in a HSC Hospital when the NIECR is non-functioning and staff are unable to print a copy.
Recoding the Cause of Death

The Cause of Death details (excluding the interval between onset of condition and death), as certified by a medical practitioner, are entered by the Registrar in the GRO’s death register and form part of that record. The entry in the death register and the Death Certificate itself are also utilised as material for the mortality statistics published by the Registrar General. These statistics are used in many fields, particularly in the study of preventative medicine, and their value will be materially enhanced if certifying medical practitioners will,

(a) read and adopt, as far as possible, the suggestions as set out below, remembering that the International Classification of Causes of Death is based, not upon terminal clinical states, but upon the antecedent and underlying pathological cause(s) of death, of which the certifier is generally best qualified to form an opinion;

(b) ensure the names of the diseases, in the case of a handwritten MCCD, are written LEGIBLY, to avoid the risk of their being incorrectly transcribed into the death register.

(c) complete the Cause of Death accurately, as absence of information may cause undue delay and anxiety to bereaved families during the registration process. Doctors are expected to state the Cause of Death to the best of their knowledge and belief.

The Cause of Death section of the MCCD is set out in two parts, in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD) as shown below.

<table>
<thead>
<tr>
<th>I</th>
<th>Disease or condition directly leading to death*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CAUSE OF DEATH</td>
</tr>
<tr>
<td>I</td>
<td>(a) ...... IMMEDIATE CAUSE OF DEATH ...............</td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
</tr>
<tr>
<td>Antecedent causes</td>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
</tr>
<tr>
<td>(b) ...... ANTECEDENT CAUSE(S)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
</tr>
<tr>
<td>(c) ...... UNDERLYING CAUSE(S) OF DEATH</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Other significant conditions contributing to the death, but not related to the disease or condition causing it</td>
</tr>
<tr>
<td></td>
<td>......OTHER SIGNIFICANT CONDITIONS ...............</td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Underlying Cause of Death

Definition
(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.
Part I - Sequence leading to death and Underlying Cause
This is used to show the immediate cause of death and any underlying cause(s).

Start with the,
- immediate, direct Cause of Death on line I (a); then
- go back through the sequence of events or conditions that led to death on subsequent lines I (b) and I (c); until
- you reach the one leading ultimately to death = Underlying Cause of Death.

This should ALL be in Part I.

If the certificate has been completed properly, the condition on the lowest completed line of Part I will have caused all of the conditions on the lines above it. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

Part II - Contributory causes
You should enter any other significant diseases, injuries, conditions, or events that contributed to the death, but were not part of the direct sequence, in Part II of the certificate.

**Part II should not contain the Underlying Cause of Death.**

For example, someone with diabetes mellitus who died of cancer might have died sooner than would have been the case if he/she did not have diabetes mellitus. If so, diabetes mellitus should be recorded in Part II as contributing to death.

However, do not enter any diseases, injuries, conditions or events that did not, in your view, contribute to the death. For example, if someone with osteoarthritis died of cancer, it is likely that osteoarthritis would not have significantly contributed to death, so it should not be mentioned in Part II.

Example 1

<table>
<thead>
<tr>
<th>I</th>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)… <strong>INTRA-PERITONEAL HAEMORRHAGE</strong></td>
<td></td>
<td>(a)…</td>
</tr>
<tr>
<td></td>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b)… <strong>RUPTURED METASTATIC DEPOSIT IN LIVER</strong></td>
<td></td>
<td>(b)…</td>
</tr>
<tr>
<td></td>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c)… <strong>PRIMARY ADENOCARCINOMA OF ASCENDING COLON</strong></td>
<td></td>
<td>(c)...</td>
</tr>
</tbody>
</table>

| II | Other significant conditions contributing to the death, but not related to the disease or condition causing it | ... **TYPE 2 DIABETES MELLITUS** | |

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
Single condition causing death
A single disease, without any antecedents, may be wholly responsible for causing death e.g. subarachnoid haemorrhage or meningococcal meningitis. In this case it is perfectly acceptable to complete only one line. In this case, it should be entered on line (a) and the other lines left blank (Examples 2, 3).

Example 2

<table>
<thead>
<tr>
<th>I</th>
<th>CAUSE OF DEATH</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease or condition directly leading to death*</td>
<td>(a)... <strong>MENINGOCOCCAL SEPTICAEMIA</strong></td>
<td>due to (or as a consequence of)</td>
</tr>
</tbody>
</table>

| Antecedent causes | (b).................................................................................................................. | due to (or as a consequence of) |
| Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last | (c).................................................................................................................. | |

<table>
<thead>
<tr>
<th>II</th>
<th>CAUSE OF DEATH</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other significant conditions contributing to the death, but not related to the disease or condition causing it</td>
<td>...............................................................................................................</td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Example 3

<table>
<thead>
<tr>
<th>I</th>
<th>CAUSE OF DEATH</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease or condition directly leading to death*</td>
<td>(a)... <strong>LOBAR PNEUMONIA</strong></td>
<td>due to (or as a consequence of)</td>
</tr>
</tbody>
</table>

| Antecedent causes | (b).................................................................................................................. | due to (or as a consequence of) |
| Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last | (c).................................................................................................................. | |

<table>
<thead>
<tr>
<th>II</th>
<th>CAUSE OF DEATH</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other significant conditions contributing to the death, but not related to the disease or condition causing it</td>
<td>...............................................................................................................</td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

More than three conditions in the sequence
The MCCD has 3 lines in Part I for the sequence leading directly to death. If you want to include more than 3 steps in the sequence, you can do so by writing more than one condition on a line, indicating clearly that one is due to the next (Example 4).
**Example 4**

<table>
<thead>
<tr>
<th>I</th>
<th>CAUSE OF DEATH</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td><strong>POST-TRANSPLANT LYMPHOMA</strong> ..........................</td>
<td></td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td><strong>IMMUNOSUPPRESSION FOLLOWING RENAL TRANSPLANT</strong> ...</td>
<td></td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td><strong>GLOMERULONEPHROSIS DUE TO TYPE 2 DIABETES MELLITUS</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>........................................................................</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>RECURRENT URINARY TRACT INFECTIONS</strong> ................</td>
<td></td>
</tr>
</tbody>
</table>

*This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Where two or more causes must be entered it is important, for purposes of correct classification, that the arrangement of causes should accurately represent the certifying practitioner’s opinion as to their order of importance and occurrence.

**More than one disease led to death**

If you know that your patient had more than one disease or condition that was compatible with the way in which he or she died, but you cannot say which was the most likely underlying cause of death, you should include them all on the same line on the MCCD and indicate that you think they contributed equally by writing “joint causes of death” in brackets (Examples 5, 6).

**Example 5**

<table>
<thead>
<tr>
<th>I</th>
<th>CAUSE OF DEATH</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td><strong>CARDIO RESPIRATORY FAILURE</strong> ..........................</td>
<td></td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(b)</td>
<td><strong>ISCHAEMIC HEART DISEASE AND CHRONIC OBSTRUCTIVE</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PULMONARY DISEASE (JOINT CAUSES OF DEATH)</strong> ......</td>
<td></td>
</tr>
<tr>
<td></td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td>........................................................................</td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
Where more than one condition is given on the lowest used line of part 1, the GRO will use the internationally agreed ICD mortality coding rules to select the underlying cause for routine mortality statistics. This will normally be the first cause that is mentioned on the lowest used line of part I. Therefore, in the example above, “Chronic hepatitis C” infection will be selected as the underlying cause of death for the purpose of producing statistics.

**Recording Healthcare Associated Infections (HCAI)**
The level of HCAIs remains a matter of concern to clinicians and the public.

The Health Service depends on accurate information gained from MCCDs to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for such as MRSA or clostridium difficile is not mentioned on a death certificate and for some families this can be a very distressing experience (Examples 7, 8, 9).

---

**Example 6**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
<th>Antecedent causes</th>
<th>Other significant conditions contributing to the death, not related to the disease or condition causing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) HEPATIC FAILURE due to (or as a consequence of)</td>
<td></td>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td></td>
</tr>
<tr>
<td>(b) LIVER CIRRHOSIS due to (or as a consequence of)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) CHRONIC HEPATITIS C INFECTION AND ALCOHOLISM (JOINT CAUSES OF DEATH)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Example 7**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
<th>Antecedent causes</th>
<th>Other significant conditions contributing to the death, not related to the disease or condition causing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) CLOSTRIDIUM DIFFICILE PSEUDOMEMBRANOUS COLITIS due to (or as a consequence of)</td>
<td></td>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td></td>
</tr>
<tr>
<td>(b) MULTIPLE ANTIBIOTIC THERAPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
It is a matter of clinical judgement if a HCAI was,
- the disease directly leading to the death [record at Part I (a)];
- an antecedent cause [record at Part I (b) or I (c)]; or
- a significant condition not directly related to the cause of death [record at Part II].

Where infection does follow treatment, including surgery, radiotherapy, anti-neoplastic, immunosuppressive, and antibiotic or other drug treatment for another disease, remember to specify the treatment and the disease for which it was given.

**Example 8**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td>(a) ... <strong>BRONCHOPNEUMONIA (HOSPITAL ACQUIRED MRSA)</strong> .................................. due to (or as a consequence of)</td>
</tr>
<tr>
<td>(b) ... <strong>MULTIPLE MYELOMA</strong> .......................................................... due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(c) ...........................................................................................................</td>
<td><strong>II</strong></td>
</tr>
</tbody>
</table>

**Other significant conditions** contributing to the death, but not related to the disease or condition causing it

... **CHRONIC OBSTRUCTIVE PULMONARY DISEASE** ...........................................

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

**Example 9**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td>(a) ... <strong>CARCINOMATOSIS AND RENAL FAILURE</strong> .................................................... due to (or as a consequence of)</td>
</tr>
<tr>
<td>(b) ... <strong>ADENOCARCINOMA OF THE PROSTATE</strong> ................................................ due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(c) ...........................................................................................................</td>
<td><strong>II</strong></td>
</tr>
</tbody>
</table>

**Other significant conditions** contributing to the death, but not related to the disease or condition causing it

... **CHRONIC OBSTRUCTIVE AIRWAYS DISEASE** ...........................................

... **CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION**

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

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FURTHER GUIDANCE REGARDING CAUSE OF DEATH TERMS

Coroner’s cases
Any Cause of Death term on the MCCD which might indicate an industrial disease, trauma, unnatural death or where the wider circumstances may require investigation, might need reporting to the Coroner.

Also, the Extra-statutory list of diagnoses contains terms that may need referred to the Coroner and a Registrar may consider it necessary to refer a case to the Coroner if one of these terms is used.

General principles
1. The statement of the cause of death should be as specific as your information allows and to the best of your knowledge and belief.

2. Tentative terms and expressions such as, “likely”, “presumably”, “probably” or “possibly” are permissible when there is not absolute certainty. They are of better use than no diagnosis at all.

3. Pay attention to providing sufficient anatomical detail e.g. aneurysm – indicate whether aortic, other artery, venous, organ affected.

4. Pay attention to providing sufficient pathological detail, for example,
   - indicate underlying disease, if cause of death due to tuberculosis, syphilis or other widely disseminated systemic disease; and
   - try to provide an underlying cause or disease when using certain terms e.g. congestion, embolism, haemoptysis, inflammation, obstruction, oedema, perforation, syncope are used.

5. The use of vague and ill-defined terms is particularly to be avoided. Incorrectly completed forms can cause difficulties for the doctor, Registrar, family, carers and relatives.

6. Do not use abbreviations (except HIV, AIDS and MRSA) or symbols on MCCDs.

7. If a Cause of Death is believed to have had a congenital origin, state this.

8. Do not use the following terms alone and without further additional qualifications or detail,
   - Organ Failure;
   - Cancer;
   - Pneumonia;
   - Infection, sepsis;
   - Malnutrition, Cachexia, Inanition
   - Old Age, General Debility of Age, Frailty, Senility and Weakness

Organ failure
Do not certify deaths as due to the failure of any organ or “multi-organ failure”, without identifying the organ(s) and specifying the disease or condition that led to the organ failure. Examples which need further information are Liver Failure, Renal Failure and Heart Failure (Example 10).
Example 10

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>Antecedent causes</th>
<th>Other significant conditions contributing to the death, but not related to the disease or condition causing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUSE OF DEATH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) ... RENAL FAILURE</td>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) ... NECROTISING-PROLIFERATIVE NEPHROPATHY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) ... SYSTEMIC LUPUS ERYTHEMATOSUS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Cancer

The terms cancer, neoplasm or tumour should be qualified with the detail of the,
  a. histological type;
  b. whether malignant or benign;
  c. whether primary or secondary (any metastatic spread);
   i. anatomical site of primary occurrence, if known;
   ii. anatomical site of secondary occurrence, if known; and
   iii. if secondary, the site of the primary and date of removal if known;

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 you specify whether you mean metastasis to, or metastasis from, the named site (Example 11).

Example 11

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>Antecedent causes</th>
<th>Other significant conditions contributing to the death, but not related to the disease or condition causing it</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUSE OF DEATH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) ... INTRAPERITONEAL HAEMORRHAGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) ... METASTASES IN LIVER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) ... from PRIMARY ADENOCARCINOMA OF ASCENDING COLON</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

If there are two sites that are independent primary malignant neoplasms, make that clear (Example 12).
If a patient has widespread metastases, but the primary site could not be determined, you should state this clearly (Example 13).

**Example 13**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) ..........................................................</td>
<td>........</td>
<td>(a) ..........................................................</td>
<td>........</td>
</tr>
<tr>
<td>Antecedent causes</td>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
<td>(b) ..........................................................</td>
<td>........</td>
</tr>
<tr>
<td>(b) ..........................................................</td>
<td>........</td>
<td>(b) ..........................................................</td>
<td>........</td>
</tr>
<tr>
<td>II Other significant conditions contributing to the death, but not related to the disease or condition causing it</td>
<td>(c) ..........................................................</td>
<td>(c) ..........................................................</td>
<td>........</td>
</tr>
<tr>
<td>(c) ..........................................................</td>
<td>........</td>
<td>(c) ..........................................................</td>
<td>........</td>
</tr>
<tr>
<td>III Other significant conditions contributing to the death, but not related to the disease or condition causing it</td>
<td>..........................................................</td>
<td>..........................................................</td>
<td>........</td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

**Pneumonia**

Bronchopneumonia, chest signs and symptoms are common terminal findings but they do not always point to significant infection being the underlying cause or contributor to death. Bronchopneumonia should not be written as the sole cause of death, if there is another condition which you can also state as the underlying cause of death.

However, if pneumonia is a cause of death, the following details should be provided, if known,

- Type or site of pneumonia (lobar, bronchopneumonia);
- Organism;
- Whether hospital or community acquired; and
- Sequence of conditions leading to pneumonia, including any relationship to aspiration or the use of mechanical ventilation.
Remember to include, in the sequence in Part I, any predisposing conditions, especially those that may have led to paralysis, immobility, difficulty swallowing, depressed immunity or wasting, as well as any chronic respiratory conditions such as chronic bronchitis (Example 14).

**Example 14**

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>Cause of Death</th>
<th>Antecedent causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) BRONCHOPNEUMONIA</td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(b) IMMOBILITY AND WASTING</td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
<tr>
<td>(c) ALZHEIMER’S DISEASE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

**Infections, sepsis**

Where possible give details about:

- Site (meningitis, peritonitis, wound site, etc);
- Organism;
- Antibiotic resistance;
- Route of infection (needle sharing, food poisoning, etc); and
- Sequence of conditions leading to death.

**Malnutrition, Cachexia, Inanition**

Because a diagnosis of malnutrition, cachexia, inanition or any term related to starvation may indicate substandard clinical care, as a result of negligence, misconduct or malpractice, it should always be considered for reporting to the Coroner.

However, if it is judged that any of the above conditions is caused by an underlying natural cause, it does not need reporting e.g. end stage dementia, gastro-intestinal pathology. If there is a decision not to refer such a diagnosis to the Coroner, the entry of that term on a MCCD must be qualified to indicate an underlying natural cause.

**Old Age, General Debility of Age, Frailty, Senility and Weakness**

The use of these indefinite terms is not encouraged. It is preferred that they are not used alone in Part I and without further supporting qualifying particulars (Example 15).

Old age should only be given as the sole cause of death when all of the following criteria have been met. The doctor,

- has personally cared for the deceased over a long period (years, or many months);
- has observed a gradual decline in the patient's general health and functioning;
- is confident that the death was expected;
• is unaware of any identifiable disease or injury that contributed to the death;
• is certain that there is no other reason that the death should be reported to the Coroner's Office; and
• the patient is 80 years or older and all the conditions listed above have been met.

It is unlikely that patients would be admitted to an acute hospital if they had no apparent disease or injury. It follows, therefore, that deaths in acute hospitals are unlikely to fulfil the conditions above.

It is possible that families, Registrars and cremation referees may request further explanation of an opinion that ‘Old age’ was the only cause of death.

Example 15

<table>
<thead>
<tr>
<th>I</th>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>HYPOSTATIC PNEUMONIA</td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antecedent causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
</tr>
<tr>
<td>(b)</td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
</tr>
</tbody>
</table>

| II | Other significant conditions contributing to the death, but not related to the disease or condition causing it |
| (c) | OLD AGE |

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Diabetes mellitus

Always specify whether diabetes mellitus was insulin dependent / Type 1, or non-insulin dependent / Type 2. If diabetes is the underlying cause of death, specify the complication or consequence that led to death, such as ketoacidosis (Example 16).

Example 16

<table>
<thead>
<tr>
<th>I</th>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>END-STAGE RENAL FAILURE</td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antecedent causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</td>
</tr>
<tr>
<td>(b)</td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
</tr>
</tbody>
</table>

| II | Other significant conditions contributing to the death, but not related to the disease or condition causing it |
| (c) | TYPE 1 DIABETES MELLITUS |

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
Terminal events, modes of dying, clinical signs 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. Very vague statements such as cardiovascular event or incident, debility or frailty are equally unacceptable.

Natural Causes
There is no ICD code equivalent to “natural causes”, and Registrars will seek clarification from the doctor, or refer the case to the Coroner. If you do not know what disease caused your patient’s death, you should discuss the case with the Coroner.

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

Deaths due to acute or chronic poisoning, by any substance, and deaths involving drug dependence or misuse of substances other than alcohol and tobacco must be referred to the Coroner.

Pregnancy, Childbirth
Whenever pregnancy, parturition or miscarriage has been in anyway a contributory cause of death, this fact should be mentioned in the MCCD and the nature of the abnormality, if any, should be provided. If, on the other hand, it is not regarded as a contributory cause, it need not be mentioned on the form.

Maternal conditions as causes of death in the newborn
In general, disease conditions recorded on a death certificate will be conditions from which the deceased suffered. However, in certifying the cause of death of a newborn infant, the practitioner may wish to record underlying conditions in the mother of the deceased infant. This may be done, although it is expected that maternal conditions will usually be regarded as a cause of infant death only in the first 28 days of life. Where maternal conditions are recorded, they should be distinguished as "maternal" (Example 17).

Example 17

<table>
<thead>
<tr>
<th>Disease or condition directly leading to death*</th>
<th>CAUSE OF DEATH</th>
<th>Antecedent causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) <strong>FETAL ANOXIA</strong> .................................................................</td>
<td>(b) <strong>MATERNAL PRE-ECLAMPSIA</strong> .....................................................</td>
<td></td>
</tr>
<tr>
<td>due to (or as a consequence of)</td>
<td>due to (or as a consequence of)</td>
<td></td>
</tr>
</tbody>
</table>

| Other significant conditions contributing to the death, but not related to the disease or condition causing it | **PREMATURITY** .............................................................................. |

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.
Steps and requirements needed when completing a handwritten MCCD

The following information should be completed accurately, as absence of information may cause undue delay and anxiety to bereaved families during the registration process.

1. **Name of Deceased**
   Provide the name of the deceased as given on the person's hospital or community records.

2. **Health and Care number of the deceased.**
   Provide the Health and Care Number of the deceased (not the hospital number).

3. **Usual residence**
   Usual residence is the person's home address. This can be a residential or nursing home.

4. **Place of Death**
   If the person died in hospital, include the hospital and ward as Place of Death.

5. **Date of Death**
   Ensure the date of death is correct to the best of your knowledge; this might not be the date of certification or completion of the MCCD form. Particular care should be taken when certifying a death that occurred before midnight but the MCCD is being completed on the following day.

6. **Date on which last seen alive and treated by me for the undermentioned conditions**
   If it is more than 28 days since the medical practitioner treated the person, he/she cannot complete the MCCD. If no doctor treated them within 28 days the death **must** be reported to the Coroner.
7. **Whether seen after death by me**

   It is good practice for the medical practitioner completing the MCCD to have seen the body. If the medical practitioner completing the MCCD did not verify life extinct, a note should be made in the clinical record by the person who did verify life extinct.

8. **Whether seen after death by another medical practitioner**

   It is good practice to state the name of the medical practitioner who examined the person after death.

9. **Cause of Death**

   State the Cause of Death to the best of your knowledge and belief. See [RECORDING THE CAUSE OF DEATH](#) section for more detail.

10. **Avoid using abbreviations**

    The only abbreviations which the registrar can accept are,
    
    - HIV for Human Immunodeficiency Virus infection;
    - AIDS for Acquired Immune Deficiency Syndrome; and
    - MRSA for Methicillin Resistant Staphylococcus Aureus.

11. **Coroner’s Reference Number**

    If contact has been made with the Coroner’s Service to discuss a death, the Coroner’s office staff will provide a Coroner’s Reference Number. This is a unique reference number and takes the form of a 6 figured number with the last 2 digits being taken from the year e.g. 0012/18 is the twelfth enquiry in 2018. This number, when completed on the MCCD, provides evidence that advice and/or instruction has been taken from the Coroner’s Service.

12. **Signature**

    Signature of the certifying medical practitioner. It is not acceptable for a MCCD to be signed on behalf of someone else i.e. with the signature preceded by p.p. (per procurationem).

13. **Name**

    Print legibly your **full name** in BLOCK CAPITALS (as registered with the GMC).
14. GMC Number
   The GMC number must be recorded. It must be your own, correct number.
   There is GMC guidance on what registered doctors must do regarding on the use of their registered name and GMC reference number. You
   must be familiar with your GMC reference number and use your registered name and GMC number when signing statutory documents. As a
   result, a doctor's registered name combined with a unique GMC reference number confers a high degree of confidence as to the identity of a
   particular doctor.
   http://www.gmc-uk.org/doctors/information_for_doctors/doctors_registration_number.asp

15. Work Address
   Include a work contact address as Registrars sometimes need to contact the doctor to clarify issues before registering the death. Difficulty
   contacting the doctor can lead to delay in funeral arrangements and distress for families.
   If hospital based, please give the ward as well as hospital.
   If a GP, please give full surgery address.

16. Work Contact number
   Include a work contact telephone number (phone or bleep, as long as they are not handed over i.e. they remain with the doctor) as Registrars
   sometimes need to contact the doctor to clarify issues before registering the death. Difficulty contacting the doctor can lead to delay in funeral
   arrangements and distress for families.

17. Date
   Provide the date the certificate is being completed.