

THE MEDICAL CERTIFICATE OF CAUSE OF DEATH

1. Introduction..... 1
 2. Your duties as a medical practitioner..... 1
 3. Personal details of deceased..... 1
 4. Circumstances of certification..... 1
 5. When to refer to the coroner..... 2
 6. Cause of death statement..... 2
 7. Employment-related death..... 3
 8. Signature of certifying doctor and name of consultant..... 3
 9. The back of the certificate..... 4

1. INTRODUCTION

Prompt and accurate certification of death is essential. It provides legal evidence of the fact and cause(s) of death, thus enabling the death to be formally registered: the family can then make arrangements for disposal of the body. Death certification also provides the raw data from which all mortality statistics are derived. These are vital for public health surveillance, for resource allocation in the NHS, and for a wide range of research - and thus ultimately for improving the health of the population.

2. YOUR DUTIES AS A MEDICAL PRACTITIONER

- 2.1 If you are a registered medical practitioner and were in attendance during the deceased's last illness, you are required under the Births and Deaths Registration Act 1953 to certify the cause of death. You must state the cause or causes of death **to the best of your knowledge and belief** (see Section 6). If you judge that the coroner may need to be informed, see Section 5.
- 2.2 Death certification should preferably be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor who was also in attendance should only occur if he/she is closely supervised.

5. WHEN TO REFER TO THE CORONER

- 5.1 There is no statutory duty to report any death to a coroner. You are nevertheless encouraged to report voluntarily any death that you judge would need to be referred to the coroner by the registrar of births and deaths (see Section 5.3).
- 5.2 **Reporting to the coroner** - you should indicate whether you have reported the death to the coroner by *ringing option 4* on the front of the certificate and initialling box A on the back. You should report to the coroner any death that you cannot readily certify as being due to natural causes.
- 5.3 A death should be referred to the coroner if:
 - the cause of death is unknown
 - the deceased was not seen by the certifying doctor either after death or within the 14 days before death
 - the death was violent or unnatural or was suspicious
 - the death may be due to an accident (whenever it occurred)
 - the death may be due to self-neglect or neglect by others
 - the death may be due to an industrial disease or related to the deceased's employment
 - the death may be due to an abortion
 - the death occurred during an operation or before recovery from the effects of an anaesthetic
 - the death may be a suicide
 - the death occurred during or shortly after detention in police or prison custody

6. CAUSE OF DEATH STATEMENT

This section of the certificate is divided into Parts I and II. Part I is used to show the immediate cause of death and any underlying cause or causes. Part II should be used for any significant condition or disease that contributed to the death but which is not part of the sequence leading directly to death.

- 6.6 **Modes of dying** - you should avoid completing the medical certificate with a mode of dying as the only cause of death in Part I. This will result in the death being referred to the coroner by the registrar. For example, 'heart failure' given alone as a cause does not indicate why the patient died. The *Underlying Cause of Death* must be given, e.g. myocardial infarction. The use of the qualification 'acute' or 'chronic' will **not** make the terms below acceptable as the sole cause of death.

Table 1. Terms which imply a mode of dying rather than a cause of death

Asphyxia	Debility	Respiratory arrest
Asthenia	Exhaustion	Shock
Brain failure	Heart failure	Syncope
Cachexia	Hepatic failure	Uraemia
Cardiac arrest	Hepatorenal failure	Vagal inhibition
Cardiac failure	Kidney failure	Vasovagal attack
Coma	Renal failure	Ventricular failure
		Liver failure

- 6.7 **Old age, senility** - do not use 'old age' or 'senility' as the *only* cause of death in Part I **unless** a more specific cause of death cannot be given and the deceased was aged 70 or over.

Part II

- 6.8 **Part II** should be used when one or more conditions have contributed to death but are not part of the main causal sequence leading to death. **Part II** should *not* be used to list all conditions present at death. For example, diabetes mellitus may have hastened the death of the patient in Example 1. In this case, the certificate should be completed as follows:

9. THE BACK OF THE CERTIFICATE

Finally, the back of the certificate contains two boxes for completion where applicable:

BOX A Put your initials here if you have formally referred the death to the coroner. You do **not** need to do this if you have merely discussed with the coroner whether to refer the death.

BOX B Put your initials here if you may later be in a position to give additional information about the cause of death (e.g. histological, microbiological, genetic, post-mortem). A request for additional information will then be sent to the certifying doctor; for deaths in hospital, the request will be addressed to the consultant responsible for the care of the patient.

2.3 There are three kinds of certificate:

- i) **Medical Certificate of Cause of Death (this book)** (Form 66): Any death occurring after the first twenty-eight days of life should be certified using the Medical Certificate of Cause of Death.
- ii) **Neonatal Death Certificate** (Form 65): Any death of a live-born infant occurring within the first twenty-eight days of life should be certified using the Neonatal Death Certificate.
- iii) **Certificate of Still-birth** (Form 34): Any death of an infant that has issued forth from its mother after the twenty-fourth week of pregnancy and which did not breathe or show any other signs of life at any time after being completely expelled from its mother should be certified using the Certificate of Still-birth.

2.4 Any infant that has breathed or shown any other sign of life is considered as live-born for registration purposes, irrespective of the period of gestation. Still-birth certificates should **not** be used for such infants.

2.5 The different forms of certificate may be obtained on request from registrars of births and deaths. The forms in this book must not be used for still-births or neonatal deaths.

2.6 You are legally responsible for **the delivery of the death certificate** to the registrar. You may do this personally, or by post, or you may ask the relative or other person who is able to give information for the death registration to deliver it as your agent. Envelopes for the purpose of delivering certificates are available from the registrar.

2.7 Before arranging the delivery of the death certificate to the registrar, please ensure that you also complete the 'Notice to informant'. This notification must be handed to the relative or other person responsible for registering the death.

2.8 You should complete the counterfoil for your records in all cases.

Part I

It is essential that you state the cause(s) of death accurately and fully to **the best of your knowledge and belief**. The death certificate is the relatives' permanent legal record of the death. The mortality statistics derived from the death certificate are vital for public health surveillance and other purposes.

- 6.1 **Underlying Cause of Death** - you should approach this by considering the main causal sequence of conditions leading to death. You should state the disease or condition that led directly to death on the first line [I (a)] and work your way back in time through the antecedents of this condition until you reach the *Underlying Cause of Death*, which initiated the chain of events leading ultimately to death. The lowermost completed line in Part I should therefore contain the *Underlying Cause of Death*.

Example 1 - An acceptable sequence for Part I

A patient died from an intracerebral haemorrhage caused by cerebral metastases from a primary malignant neoplasm of the left main bronchus.

This should be entered as follows:

Disease or condition that led directly to death	I (a) Intracerebral haemorrhage
↑	
Intermediate cause of death	(b) Cerebral metastases
↑	
Underlying Cause of Death	(c) Squamous cell carcinoma of left main bronchus

The *Underlying Cause of Death* in this case is squamous cell carcinoma of the left main bronchus.

Example 3 - Other conditions contributing to death

Disease or condition that led directly to death	I (a) Intracerebral haemorrhage
↑	
Intermediate cause of death	(b) Cerebral metastases
↑	
Underlying Cause of Death	(c) Squamous cell carcinoma of left main bronchus
↑	
Other conditions contributing to death	II Diabetes mellitus

- 6.9 **Interval between onset of conditions and death** - if possible, it is also important to state the *approximate* interval between the onset of each condition and death for Parts I and II, as this information is used for coding purposes. For example, the following intervals might be appropriate:

Example 4 - Interval between onset of condition and death

Disease or condition that led directly to death	I (a) Intracerebral haemorrhage	6 hours
↑		
Intermediate cause of death	(b) Cerebral metastases	3 months
↑		
Underlying Cause of Death	(c) Squamous cell carcinoma of left main bronchus	2 years
↑		
Other conditions contributing to death	II Diabetes mellitus	10 years

REMINDEES

Numbers in parentheses are cross-references to sections in the detailed notes on pages 1-4.

Should you complete the certificate? Is this the correct certificate?

If you attended the deceased during his/her last illness, you are required to complete a Medical Certificate of Cause of Death. Death certification should preferably be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor should only occur if he/she is closely supervised (2.1-2.2). The certificates in **this booklet must only be used** for deaths at ages over 28 days. Still-births (deaths after 24 weeks of pregnancy) and neonatal deaths (deaths up to 28 days of life) must be registered on other certificates, obtainable from the registrar of births and deaths (2.3-2.5).

What is the underlying cause of death? Details of infection or tumour?

You must state the cause or causes of death **to the best of your knowledge and belief**. Check that the *underlying cause of death* appears as the last completed line in Part I of the certificate - see examples in Section 6. If you record an **infection**, state the organism, site and duration if possible. If you record a **tumour**, state the anatomical site of the primary, the morphology and the behaviour (malignant, benign, *in situ*, etc.), if possible. If you state metastases or disseminated malignancy, give the site of the primary if known.

Were there contributory causes of death?
 Enter in Part II of the certificate any condition which contributed to death but was not part of the main causal sequence (6.8).

How long before death?
 Include time intervals between the onset of each condition and death, where known. The intervals can be invaluable for correctly assigning the underlying cause of death for mortality statistics (6.9).

HOW TO COMPLETE THE CERTIFICATE

3. PERSONAL DETAILS OF DECEASED

- 3.1 **Age** - you should record the age of the deceased in completed years or, if under one year, in completed months.
- 3.2 **Place of death** - you should record to the best of your knowledge the precise place of death (e.g. the name of the hospital or the address of a private house or, for deaths elsewhere, the locality). This may not be the same as the place where you are completing the certificate. It is particularly important that the relative or other person responsible for registering the death is directed to the registrar of births and deaths for the sub-district where the death occurred, unless (from 1 April 1997) they have decided to make a declaration of the details to be registered before another registrar.

4. CIRCUMSTANCES OF CERTIFICATION

- 4.1 **Last seen alive by me** - you should record the date when **you** last saw the deceased alive, irrespective of whether any other medical practitioner saw the person alive subsequently.
- 4.2 **Information from post-mortem** - you should indicate whether the information you give about the cause of death takes account of a post-mortem. Such information can be valuable for epidemiological purposes.
 - If a post-mortem has been done, *ring option 1*.
 - If information may be available later, do not delay the issue of your certificate, *ring option 2* and tick statement B on the reverse of the certificate. The registrar will then send you a form for return to the Registrar General giving the results of the post-mortem.
 - If a post-mortem is not being held, *ring option 3*.
- 4.3 **Seen after death** (only one option can be ringed) - you should indicate, by ringing option a, b or c, whether you or another medical practitioner saw the deceased after death.

6.2 For some deaths there may be only one condition which led directly to death with no antecedents, e.g. subarachnoid haemorrhage or meningococcal meningitis. In this case it is perfectly acceptable to complete only line [I(a)].

6.3 Your statement of the cause of death should be as **specific** as your information allows. For example, when recording a neoplasm state the histopathology, whether malignant or benign, the anatomical site, whether primary or secondary and, for the latter, the site of the primary and date of removal if known. In Example 1, cerebral metastases resulting from squamous cell carcinoma of the left main bronchus is given, rather than simply lung cancer.

6.4 **Joint causes of death** - sometimes there are apparently two distinct conditions leading to death. If there is no way of choosing between them, they should be entered on the same line indicating in brackets that they are joint causes of death. In such cases, the first condition will be taken as the *Underlying Cause of Death* for coding purposes.

Example 2 - Joint causes of death

Disease or condition that led directly to death	I (a) Ischaemic heart disease and chronic bronchitis (joint causes of death)
↑	(b)
Intermediate cause of death	
↑	
Underlying Cause of Death	(c)

- 6.5 **Smoking** - inclusion of the term 'smoking' is acceptable if accompanied by a medical cause of death.

6.10 **General points** - Where appropriate, in Parts I and II, you should give information about clinical interventions, procedures or drugs that may have led to adverse effects.

6.11 If you use a term such as 'cerebrovascular accident', which may be misinterpreted by a lay person as implying violence, take care to explain it to the relatives.

6.12 Avoid abbreviations such as CVA, MI, or PE on the certificate. This also applies to medical symbols. Inclusion of such ambiguous terms may delay registration.

6.13 Bronchopneumonia is a common terminal event in patients with a major chronic illness. Do **not** write bronchopneumonia as the **sole** cause of death if another condition(s) can be identified as the *Underlying Cause of Death*.

7. EMPLOYMENT-RELATED DEATH

If you believe that the death may have been due to (or contributed to by) the employment followed at any time by the deceased, you should indicate this. Tick the appropriate box on the front of the certificate and *then report it to the coroner* (see Section 5). Employment-related causes of death are listed on the back of the certificate and a more detailed list is given in subsequent pages. If, however, it is known that the disease in question was non-industrial, you should add the words 'non-industrial' to the cause as recorded on the certificate, and the death need not be referred to the coroner.

8. SIGNATURE OF CERTIFYING DOCTOR AND NAME OF CONSULTANT

You must sign the certificate and add your qualifications, address and the date. It would greatly assist the registrar if you could also **PRINT YOUR NAME IN BLOCK CAPITAL LETTERS**. If the death occurred in hospital, the **name of the consultant** who was responsible for the care of the patient **must also be given**.

Avoid abbreviations, vague terms and symptoms.
 Do not use **abbreviations** or **medical symbols** - they can be ambiguous (6.12). Do not use "old age" or "senility" as the sole cause of death in Part I **unless** a more specific cause of death cannot be given and the deceased was aged 70 or over (6.7). If you record a **symptom**, state also the underlying disease.

Should the death be referred to the coroner? Explain to the relatives.
 You will spare the relatives unnecessary delay and anxiety if you refer relevant deaths to the coroner directly (see checklist in Section 5.3). If in doubt, contact the relevant coroner's office for advice. If you do refer to the coroner, **circle option 4 and initial Box A** on the back of the certificate (5.2). Explain to the relatives why you are referring the death. The registrar is obliged to refer a death to the coroner if the medical certificate is not correctly completed.

More information available later?
 If you may be able to provide **more precise information** about the cause of death later (for example with the results of laboratory tests or a post-mortem), initial Box B on the back of the certificate (9).

Have you remembered - signature, notice to informant, counterfoil?
Sign the certificate, adding your qualifications, residence address and the date. You should also **PRINT YOUR NAME IN BLOCK CAPITAL LETTERS**. For hospital deaths, enter the **name of the consultant** responsible for the care of the patient (8). **Complete the Notice to Informant** and give it to the relatives (2.7). Don't forget to **complete the counterfoil** (2.8).