

## Death Certification Review Service

### *Tips for Certifying Doctors when completing a Medical Certificate of Cause of Death (MCCD)*

- Read the published [CMO Guidance](#) and complete the [on-line training](#) about Death Certification . There is an on-call medical reviewer available for advice during working hours and also out of hours.
- It is the statutory duty of the doctor, who has “attended” the deceased during the last illness, to issue the MCCD. There is no clear legal definition of “attended”, but it is generally accepted to mean a doctor who has cared for the patient during the illness or condition that led to death or failing that a doctor who can access the patient’s medical records. The certifying doctor should have access to relevant medical records and the results of investigations. You can complete a certificate if you have not personally attended the patient but you have to be in a position to certify to the best of your knowledge and belief and willing to be personally accountable.
- If you cannot issue an MCCD you should contact a colleague who can, or discuss/report to the Procurator Fiscal.
- In all cases, consider whether there is any reason to report to or discuss the case with the Procurator Fiscal for example: trauma has been identified as a cause or contributor to death no matter how long ago, due to an industrial disease including asbestosis or there is a complaint about the care provided prior to death.
- Be clear whether you have formally reported a case to the Procurator Fiscal, if you have, tick the PF box. If the case has otherwise been reported to the Fiscal and you have agreed to produce an MCCD at their request, then you should tick the box. If you have discussed a case and agreed with the Procurator Fiscal that the case does not need to be formally reported, then do not tick the box.
- Use electronic completion of the MCCD if possible. If using an electronic MCCD the legal document continues to be the printed copy and must still be signed and physically given to the informant to register the death. It must not be watermarked DRAFT. (Copies watermarked DUPLICATE are acceptable when signed.)
- Your writing should be in CAPITALS using BLACK ink throughout when completed by hand.
- Correct spelling is important.
- The time of death is the time that to the best of your knowledge and belief you think the patient died and NOT the time that death was later verified.
- Use business telephone numbers; do not include personal mobile numbers.
- If the patient died in hospital, you should include the ward or the department where the patient died.
- It is expected that senior staff identified as responsible for the patient are aware of what is entered as cause of death on the MCCD in keeping with the CMO Guidance.
- The causes must make sense both medically and chronologically. If you use more than one line in section 1 then what is entered on a lower line must have led to the condition in the line above. Intervals likewise should be sequential.
- You must not include any abbreviations except for HIV, AIDS, COVID-19 or SARS-CoV-2 which are permissible. Do not use the word "accident", e.g. cerebrovascular accident is not allowed, use ‘stroke’ or a more specific description instead.
- A stroke should be given as ischaemic or haemorrhagic if known. Give the anatomical area and side affected if known.
- The causes certified, should be able to convey to another doctor what caused the death of the patient.
- You must be prepared to explain cause(s) of death in a way that a bereaved relative may easily understand.
- If smoking, alcohol or obesity have significantly contributed to the death e.g. associated with cancer or cirrhosis then they should be included. Use "Previous smoker" rather than "ex-smoker" for clarity.

- Cancer histology, sites and organisms in infections, including resistance and routes of infection are important and should be entered if known.
- Metastases are important and may occur at different times, if multiple please use interval from the time metastases were first identified.
- If you wish to enter a cause of death that you believe is the case but you have no confirmatory evidence, you can qualify it with "Probable" or "Presumed".
- In causation, intervals must be provided for all items with the exception of "Old Age" which may be allowed in certain circumstances, most commonly in an unexplained gradual decline leading to death in a patient over 80. Congenital conditions also, do not need an interval but add "since birth" to the term.
- Intervals should have a figure in at least one column, not ticks, and indicate the approximate interval between onset and death. If the death was due to a sudden event give the interval as one day.
- In relation to COVID-19 related deaths "COVID-19 disease" is the preferred term. If the disease is suspected but not confirmed, you may write: "Presumed COVID-19 disease". "Post-COVID-19 syndrome" is the correct term for disease causing symptoms past 12 weeks.
- Consider in all cases if the body may present an infectious hazard. In this evolving situation, the CMO advises that if COVID-19 is given as cause of death on the MCCD, then the DH1 hazard box should be ticked. If there was a positive COVID-19 test in the last 28 days, even without it contributing to the death and so not included on the MCCD, the DH1 hazard box should still be ticked.
- Report to the Fiscal if COVID-19 disease was contracted in a care or residential home or as a result of the deceased's occupation. If the disease was contracted while in hospital and the family or staff are concerned, then consideration should also be given to reporting the case to the Fiscal.
- None of the form is optional and all parts and questions on both sides should be considered and answered as appropriate.
- Hazards must be entered and should be ticked in the appropriate box, use a tick or a cross. The hazards are important for those who may have to handle the body etc. for embalming or particularly for cremation and the possibility of contamination or explosion. Remember patients may have dangerous implants or infections that are completely unrelated to the cause of death. Failure to complete or to do so incorrectly means that the whole certificate must be re-issued.
- The extra information box should only be ticked if there is significant information awaited for example: a laboratory result; histology from a tumour that has not yet been identified or a post mortem report.
- National Records of Scotland randomly selects MCCDs for review; this does not indicate you have done anything wrong. If you complete an MCCD that is subsequently selected for review, this does not necessarily mean there is anything of concern, even if changes are requested as a result of the process, this will not necessarily result in any adverse criticism of you as DCRS has adopted an educational and supportive approach. Reviews are mostly random. DCRS are primarily interested in accurate representation of the cause of death.

**Contact us:**

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