Healthcare Improvement Scotland

Deaths from COVID-19 disease in Scotland:

Scenarios to support accurate death certification and reporting to Crown Office & Procurator Fiscal Service

This Scottish guidance has been produced by the team at the Death Certification Review Service, part of Healthcare Improvement Scotland.
It is based on documents published by the Crown Office and Procurator Fiscal Service (COPFS)[1] and the Chief Medical Officer[2, 3, 5].

A doctor must complete the Medical Certificate of Cause of Death (MCCD) to the best of their knowledge and belief, taking into account all the clinical evidence they have available. As COVID-19 is a new disease, this guidance may evolve over time.

The World Health Organisation (WHO) has confirmed that for the purposes of the International Classification of Diseases (ICD), the official name of the disease is Coronavirus disease (COVID-19).

The official name of the Virus by the International Committee on Taxonomy of Viruses (ICTV) is Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). Therefore, COVID-19 disease or SARS-CoV-2 infection on the MCCD are acceptable, however the preferred wording on the MCCD is “COVID-19 disease”. This is an acceptable abbreviation.

SARS-CoV-2 is a notifiable organism and COVID-19 disease is a notifiable disease.

Reporting of some COVID-19 deaths to the COPFS

The Scottish Government confirmed that deaths due to COVID-19 disease or SARS-CoV-2 infection or presumed COVID-19 disease or SARS-CoV-2 infection do not require reporting to the Procurator Fiscal (PF) unless:

1. A person has COVID-19 or presumed COVID-19 but the death falls under another category defined by section 3 of the COPFS guidance to medical practitioners. This includes deaths which may cause public anxiety (for example outbreaks of COVID-19 in hospital wards) or where a concern from a family member or doctor has been raised.

2. Any death due to COVID-19 or presumed COVID-19 in the following situations:

    a. where the deceased was resident in a care home (this includes residential homes for adults, the elderly and children) when the virus was contracted or

    b. where to the best of the certifying doctor's knowledge, there are reasonable grounds to suspect that the deceased may have contracted the virus in the course of their employment or occupation. Whilst not exhaustive, this may include deaths of care home workers, frontline NHS staff, emergency services personnel and public transport workers.

Completing the Hazards section DH1 of the MCCD

As SARS-CoV-2 is infectious and COVID-19 is a notifiable disease, in acute infections the body of the deceased may pose a risk to those handling the body after death. As such, the DH1 box must be ticked.

For how long after contracting COVID-19 does the body continue to pose a risk to public health?

The duration that a person remains infectious and able to transmit corona virus is uncertain. It is likely that transmission of SARS-CoV-2 is maximal in the first week of illness[4], however it is not yet known how long a body remains infectious. Current CMO guidance is that if COVID-19 is on the certificate as a cause of death, the hazards box DH1 should be ticked, this includes deaths not related to COVID-19 although testing positive for the virus within 28 days of the death[5].

Whether the body of a person who has died after having COVID-19 disease remains a risk to others is a matter of clinical judgement for the certifying doctor.

A doctor must complete the Hazards section of the MCCD to the best of their knowledge and belief. It is advisable to be prudent. If in doubt, the doctor can discuss the case with the local Public Health team to seek their guidance.

Scenarios

Scenario 1 Amelia

Amelia was a frail 85 year-old lady who was mobile around her residential home and cognitively intact. She developed COVID-19 and was confined to bed.

After two weeks she improved but required assistance to walk

short distances. For two months, despite rehabilitation she was largely confined to a chair and then latterly her bed. For the last month of her life she ate less and less. She was unable to eat or drink anything for a week before she died.

A suggested sequence

1a	Increasing physical frailty and reduced mobility	2 months
1b	COVID-19 Disease	3 months

Clinical Reasoning

In this case, the certifying doctor judges that COVID-19 has resulted in this lady's death by causing her stepwise deterioration from the time of her initial infection.

Procurator Fiscal

As this is a case of COVID-19 contracted in a residential or care home, it must be reported to the PF.

DH1 Hazard

A clinical judgement must be made as to whether the body still poses a risk to those handling the body after death. For such a historic infection it is unlikely there is any risk. If in doubt, the doctor can discuss the case with the local Public Health team to seek their guidance.

Current CMO guidance is that if COVID-19 is on the certificate as a cause of death, the hazards box DH1 should be ticked. This includes deaths not related to COVID-19 although testing positive for the virus within 28 days of the death.

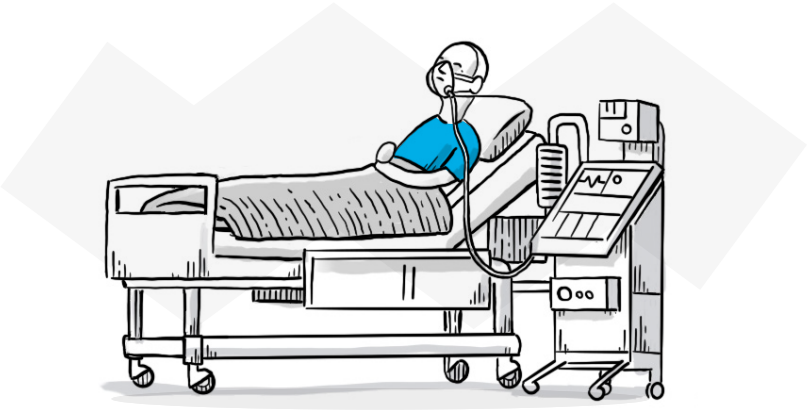
Scenarios

Scenario 2 Angus

Angus was a 48 year-old labourer who was overweight with a BMI of 34 but no other health problems.

He developed COVID-19 at home and was admitted with increasing shortness of breath. After 3 days he developed an increasing oxygen requirement and was moved to ICU. He had routine thromboprophylaxis. He remained stable over a week, but suddenly deteriorated. CT pulmonary angiogram confirmed a large saddle pulmonary embolus and despite treatment, he sadly died.

His family had no concerns about the care provided and were grateful to the staff.



A suggested sequence

1a	Pulmonary Embolism	1 day
1b	COVID-19 Disease 17 days	17 days
Part 2	Obesity	10 years

Clinical Reasoning

In this case, the certifying doctor judges that the pulmonary embolism occurred as a known risk of having severe COVID-19. They believe that Angus' obesity had contributed to his death from COVID-19, hence it appears in part 2 as a contributor.

Pulmonary embolism has been identified separately in 1a with COVID-19 as an underlying condition.

Procurator Fiscal

There is nothing in this case that appears to require a report to the PF.

DH1 Hazard

In such an acute infection, the DH1 box should be ticked.

Scenarios

Scenario 3 Mabel

Mabel was an 88 year-old lady who was an in-patient in a long term NHS care ward. She had advanced mixed Alzheimer's and vascular dementia. She required hoisting for all care. She developed a fever of 38.2 degrees centigrade and a mild cough. She was breathless with oxygen saturations on air of 88%.

Sadly, she deteriorated rapidly and died the next afternoon. There were three other proven COVID-19 cases in the ward. The COVID swab that was taken from her was accidentally mislaid.

A suggested sequence

1a	Suspected COVID-19 disease	2 days
Part 2	Mixed Alzheimer's and vascular dementia	5 years

Clinical Reasoning

In this case, the certifying doctor judges that COVID-19 was the most likely direct cause of death due to the clinical features and other cases in the ward. Without a swab to confirm the diagnosis, they use a qualifier (Suspected / Probable etc.) to convey that this is their best clinical judgement of the cause of death.

They judge that her dementia is a contributor to the death in Part 2.

Procurator Fiscal

As this is suspected case of nosocomial COVID-19 contracted as part of an outbreak in a ward, it is a cause for public anxiety and should be reported to the PF.*

DH1 Hazard

DH1 Hazards: As an acute suspected case of COVID-19, the DH1 box should be ticked "yes".

*A case of nosocomial infection by itself is not a reason to report to the PF unless any of the additional categories in section 3 of the COPFS guidance to medical practitioners are present.

References

1. Crown Office and Procurator Fiscal Service. Reporting deaths to the procurator fiscal. Information and guidance for medical practitioners. 2019.
   https://www.copfs.gov.uk/investigating-deaths/deaths

2. Chief Medical Officer. Re: Updated Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic. 2020.
   https://www.sehd.scot.nhs.uk/cmo/CMO(2020)15.pdf

3. Chief Medical Officer. Guidance for doctors completing medical certificates of the cause of death (MCCD) and its quality assurance. 2018.
   https://www.sehd.scot.nhs.uk/cmo/CMO(2018)11.pdf

4. Cevik M, Kuppalli K, Kindrachuk J and Peiris M. Virology, transmission, and pathogenesis of SARS-CoV-2. BMJ 2020;371:m3862.
   https://doi.org/10.1136/bmj.m3862

5. Chief Medical Officer. Re: Updated guidance to medical practitioners for death certification and reporting deaths to the Procurator Fiscal during the COVID-19 pandemic. 2022.
   https://www.sehd.scot.nhs.uk/cmo/CMO(2022)17.pdf

Further Information & Useful Links

Healthcare Improvement Scotland - Death Certification Review Service

Phone: **0300 123 1898**

Email: **his.dcrs@nhs.scot**

HIS webpage:

https://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification.aspx

NHS Education for Scotland Support Around Death website

Educational resources & information on:

Death certification

http://www.sad.scot.nhs.uk/atafter-death/deathcertification/

The Scottish MCCD Review process

http://www.sad.scot.nhs.uk/atafter-death/the-scottishmccd-review-process/

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