NHS Education for Scotland

Transcript of 'Accurate Completion of the Medical Certificate of Cause of Death Transcript' (NES Bereavement Webinar, 2021) video.

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Speakers:

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Kenneth Donaldson (KD): Hello, good evening to everybody that's joined tonight's webinar. I want to welcome you to what is our 13th NES Bereavement Webinar. Can't quite believe we've got to the 13th one.

My name's Ken Donaldson. I'm one of the Associate Postgraduate Deans for Grief and Bereavement at NES, I'm also a Medical Director and Nephrologist down in Dumfries and Galloway. So, as I said, welcome to everybody, that's joined us. The title of tonight's webinar is "Accurate Completion of the MCCD." I'm delighted to welcome Doctors Rosie Conway and Steven Mills, who will be giving tonight's presentation.

Just to give you a little bit of background into them. Rosie trained in palliative medicine in New Zealand and Dundee and was a consultant in palliative medicine in NES NHS Tayside for 12 years, until 2018. Since then, she's been a Medical Reviewer with the Death Certification Review Service two days a week. She also has roles in the Medical School at Dundee teaching communication and clinical skills and mentoring students admitted through the Widening Participation Programme. And Steve trained in general practice. He was a GP Principal in Lancashire Lanarkshire for nine years. He was also a GP trainer. More recently he enjoyed a part-time role as a Specialty Doctor in palliative care. He joined the Death Certification Review Service in May of 2020, and currently performs the role four days a week. And in addition to the role of Medical Reviewer with the DCRS, he enjoys a part-time teaching role at Glasgow University teaching communication skills.

So, I'm just going to run through some quick bits of housekeeping. I realise my microphone's not very good so I have to lean in so you can all hear me properly. I hope you're hearing me. And tonight's structure, the session will be about 45 minutes for the presentation and hopefully around 10 minutes for questions at the end. So, what we're going to do is before we kick off the presentations, we're going to do a short poll just to gauge your current level of confidence in completing MCCDs.

So, I think that's it live now. So, if you want to just click on either one, not at all confident, working through five where you're very confident. Okay, so there we go. We've got the results in now.

Well, it's good to see that the majority... There's no percentages, I can't see any. But the majority are putting four. It's probably about maybe a third or so. And then kind of increments down three and two to one, not at all confident, maybe, I don't know, 10, 13%. I'm not sure if there are percentages showing. Oh, there are, sorry. My box was covering. So, 11%, not at all confident, working up to 42% who are feeling reasonably confident with a smaller group of you at 5% saying you're very confident.

So, we'll now move on to the webinar itself. And we'll repeat this poll at the end, just to see if we've managed to increase the numbers down to four and five. So, I shall hand over to yourself, Steve, I think it's you are going first. If that's fine.

Steven Mills (SM): Correct. Yep. Thanks very much for that, Ken, for the introduction and also for inviting Rosie and I to speak today.

So, we're going to give an overview on the accurate completion of the MCCD. And I believe we've got quite a wide range of attendees today, which range from maybe medical students who've never completed a certificate to experienced GPs or consultants who have completed these over many years. But hopefully, everyone will be able to take something new from the session.

Just a quick acknowledgement, I'd like to thank Dr McCullough and Dr McLaughlin, who are two of our colleagues who helped us with the content and the slides for the presentation.

Thanks also to Phil and Rozanne at NES for guiding us through the webinar process, which is new to both me and Rosie. So well done to both of them. But really in particular, thanks to all of you guys. You've taken time out of I'm sure a very busy Tuesday afternoon to join us. We're really quite delighted with the registration figures and the interest the topic has received.

So, the agenda today, really quite simple, we're going to spend a very short time just talking about the purpose of death certification and then a longer period walking through the death certificate itself and giving some examples of death certificates.

Thought we'd just start with a quick quiz. Now, many of you may know the answers to these, you may not. If you don't know the answers to these, hopefully by the end of this webinar, you will know the answers to them.

That's our aim anyway. So quick quiz. Does active hepatitis B virus count as a hazard in the DH1 section of the MCCD? My patient died from a hypoxic brain injury two days after a suicide attempt.

Should I issue a death certificate? Cerebrovascular accident is allowed to be written on death certificates? TNM staging is encouraged to be on the MCCD for cancer deaths?

Filling in the durations of conditions is optional? And this patient died in hospital after being transferred from prison, still in custody when he died, does this need to go to the fiscal? So, as I said, many of you may know the answers to these, many of you might not. And hopefully if you don't, then you will by the end of this session. So just starting then with the MCCD.

So, it's a statutory legal document. It records the fact of death and on it has a doctor's signature attesting to a truthful and accurate account. Accurate completion of the MCCD is a statutory requirement for all registered doctors in the UK. It does permit relatives to formally register the death and plan the funeral, but it also gives relatives an explanation of how and why their relative died. And also, just as importantly, it may provide family with information, important information about conditions which may be important for them or for future generations. Relatives also require an extract of the registration of death to settle the estates and also for public health purposes.

So, recording of mortality data, monitoring the health of the nation, formulating public health policy, assessing the effectiveness of health services and designing healthcare programmes and resource allocation and spending priorities. So quick overview of that, and just a very quick point on the basics of the MCCD just before we get to the actual nuts and bolts of filling it in. Simple things that we sometimes discuss on a day-to-day basis. Junior staff should really discuss the cause of death with a senior colleague or discuss the MCCD contents with a senior colleague. Especially important for FY1 doctors. Important to write clearly especially if you're doing a paper certificate in hospital or in a hospice.

If you don't write clearly, then there can be transcription errors and the registrar may not be able to read what you've written, you may need to do it again, or there could be errors on the certificate because of that. Do use a business contact telephone number, and don't use a personal mobile number and do check your spelling.

It is a legal document. So, there can't be any spelling errors in it. And if there are spelling errors, even if they're just minor typos, then the registrar will come back and request that you amend them. So important to get it right the first time essentially. Don't use abbreviations other than the ones below.

So those ones are okay on a death certificate, the registrars will accept HIV, AIDS, COVID-19 disease and SARS-COVCoV-2. They won't accept any other abbreviations. So, COPD, CKD, MRIs, et cetera. Again, they will come back to you, and you'll have to either amend that or do a replacement certificate.

And please be as specific as you can. That includes types of dementia. So, Alzheimer's or vascular, site and histology of cancer. So put the pathology, if you have it, squamous cell carcinoma or adenocarcinoma. The type and the site of stroke should be added as well as the site in microbiology of any infections. So, if you know the bug that caused, say, the sepsis, then add it to the certificate. And obviously don't add abbreviations. So, write out the full name of the bug, even if it does mean you have to look it up to spell it, which is certainly what I would have to do. Certainty is not required, but you must certify to the best of your knowledge and belief. So, an important point here really. If you do feel that you're able to certify to the best of your knowledge and belief, you don't have to be 100% certain about conditions on the MCCD.

And very importantly, you may use qualifiers, so presumed, suspected or probable in front of the condition. And that's quite clear on the CMO guidance as well. So absolutely fine to use qualifiers if needed. I suppose an example there in the community, would be something like probable myocardial infarction.

That's absolutely fine to use if that's what you feel was the cause there. And again, it's the second last point on this, but it's certainly not the least important. Consider if the death is reportable to the Procurator Fiscal. It's the first question we ask in our reviews at DCRS. The fiscal guidance is quite handy just to have as a document by your desktop for when you're completing the death certificate.

And we'll talk a bit more about reporting to the Procurator Fiscal later on in the webinar. So just moving on to the certificate, then time of death, this is quite often asked. And the time of death is the time that to the best of your knowledge and belief, you think the patient died. It's not the time that the death was subsequently verified or confirmed. And it's important to give one date and time on the certificate.

So, an example, I suppose, would be a family phone in, their relative is maybe an expected death. And they phone into the practice and say that they passed away at 10:30 in the morning.

A GP goes out and certifies the death at 12 o'clock, it should be 10:30 that should go on the certificate. And again, the CMO guidance is quite clear that you can use information given to you by families or nursing staff for the time of death there.

So, time that they passed, not time verified. And this is a useful slide, I think. And this is the nuts and bolts of the certificate. So, part one in part two, and the causes of death and the contributors to the death. So essentially this is the area where you tell the story of how a patient died and each line in part one, so the line below either caused or created the circumstances for the line above.

Line 1A is the condition that directly led to the death. For example, say myocardial infarction. 1B would then be the condition that caused or created the circumstances for the MI.

So perhaps ischaemic heart disease. And then 1C, what caused the ischaemic heart disease? Well, it may not be anything that caused the ischaemic heart disease, but you may feel that say hypertension was the 1C because that created the circumstances for the ischaemic heart disease.

And if that's the case, then you put that in 1C. As the red line shows, basically, the oldest condition should be the one at the bottom and the earliest condition should be the one at the top. So, the timing and the duration of part one should be sequential there. Essentially, you should be able to go back through the sequence of events or conditions on subsequent lines in part one, until you reach the one that started the fatal sequence. And what's quite important really is the underlying line in part one. So, the lowest line, completed line in part one usually will be selected as the underlying cause of death.

And from a public health point of view, preventing that particular condition will lead to greater health gain than preventing anything above it. So important to get the sequence right there.

Moving on to the contributors. So, part two are contributors. Basically, conditions contributing to the death, but not part of the above sequence.

And the CMO guidance actually describes them. Basically, a contributor made someone more vulnerable to the fatal condition or weakened the person. So, death occurred sooner than otherwise would've been the case. So, it's not somewhere that you can just put the past medical history. It is conditions that basically contributed to the death. I often talk about contributors being, if you think about the condition, if it wasn't for that condition, would that person still have died at the same time? And if that is the case, then it likely is a contributor to the death.

So, did it accelerate the death? And that would be your part two there. Okay. Moving on to durations on the certificate. So, the minimum duration for a condition is one day, you can't put zero days or leave it blank. It is one day.

So, if you had an acute MI say that happened, even though perhaps it was 10 minutes, you would use one day as the shortest duration on the certificate. The approximate interval between the onset of each disease, injury or conditions should be used for each line in part one and in part two.

And the only conditions that don't need a duration are old age and congenital conditions. Everything else, you should try your best to get a duration in there. And ticks aren't acceptable in the durations box. It needs to be a number.

What I would say is that only one of the boxes needs to be completed. So, you do get very conscientious doctors that say a patient had a condition for 20 years, four months and four days and will complete the certificate in that order. If it's been something for 20 years, four months and four days, then 20 years is fine.

You don't need to fill in the other two boxes essentially. So just moving on to some examples of reasonable sequences. First example here, we've got a 65-year-old man with NSTEMI elevation myocardial infarction three years ago, ongoing exertional angina, also has severe COPD with an FEV1 of 40%, osteoarthritis, depression and gout.

He rang 999 because of chest pain. And the paramedics arrived to find him collapsed and nonresponsive with VF on ECG and CPR, sadly unsuccessful.

So as the general practitioner, you may be asked to do a certificate here, and the general practitioner in this case has decided that he is able to issue to the best of his knowledge and belief.

And he's decided that basically, with the information that they have, the history and the past medical history, he feels most likely cause of death here was a probable myocardial infarction and is putting that at 1A with the condition that caused or created the circumstances for that myocardial infarction being the ischaemic heart disease of three years.

Doesn't have the conditions that weren't contributors to the death. So, the OA, the depression and the gout weren't felt to be contributors here. They didn't accelerate the death. However, the COPD was felt to be a contributor and was added to part two because of that. Again, I've mentioned this already, but again, certainty about the cause of death isn't required. And again, the CMO guidance is quite clear on that.

You can use qualifiers such as presumed or probable, and that's absolutely okay to do. So, another example, woman, 72 years old, past medical history of type one diabetes, hypertension, previous lacunar infarct, an SCC of the oesophagus four months ago which was stented, but she's losing weight. And she was admitted with a dense left hemi, and CT brain showed a right total anterior circulation and a stroke.

And she dies as a result of the stroke. So, certificate here, the doctor had decided that the total anterior circulation, cerebral infarct, was the direct cause of death and the condition that caused or created the circumstances for that was the cerebral cerebrovascular disease.

Now, the conditions that caused or created the cerebral cerebrovascular disease in this case, the doctors felt that that was the type one diabetes and the hypertension.

And so quite rightly they've put down type one diabetes, mellitus and hypertension, and they've put joint causes in brackets after that, which is absolutely the right way to do it. If you feel that it's really 50-50, both conditions caused the cerebrovascular disease so you're going to put them both on the same line and then, very importantly, put joint causes in brackets after that to let the registrar know

that it was both of these conditions. And then the contributory factor here, it was the squamous cell carcinoma of the oesophagus in part two. Another quick tip, CVA will be rejected by the registrar. So obviously CVAs are abbreviation anyway, but if you put cerebral cerebrovascular accident, that will be rejected by the registrar. They won't accept ‘accident’ on the certificate as cerebrovascular accident.

So cerebral cerebrovascular event is okay, ischaemic stroke is okay. But cerebrovascular accident will come back from the registrar there. So, moving on to a very important part. I mean, all the death

certificate is very important, but the Hazard Section. So, hazards must be entered on the certificate, and they must be correct, or it is an automatic re-issue. You would need to re-issue the certificate if the hazards were incorrect.

Always advised that to use ticks and not Y or N or crosses in the hazards box. And just be aware that there may be hazards unrelated to the cause of death. So, they may not be in part one or part two, but they're still a hazard. I suppose, an example of that would be perhaps in COVID. A patient tested positive for COVID near the end of their life but died of something completely unrelated and the doctor didn't feel that it was a cause of death, nor it was a contributor to their death.

So, it didn't appear in part one or part two. However, they should still tick the DH1 box as it is a notifiable infectious disease and that there may be a hazard to handling the body from an acute infection there. So important to remember that there may be hazards there that aren't in part one or part two. So just some examples of hazards then. Just to highlight, this is by no means an exhaustive list.

So, these are just some examples. Start off with DH1. So DH1, does the body of the deceased pose a risk to public health? For example, did the deceased have a notifiable infectious disease or was the body contaminated immediately before death?

So, examples there, blood borne viruses such as hepatitis, COVID, SARS, or MERS, viral haemorrhagic fevers, prion disease and some bacteria such as active TB or meningococcal disease. Again, that's not an exhaustive list. There is many, many more that would be a DH1 hazard.

And DH2, is there a cardiac pacemaker or any other potentially explosive device currently present in the deceased? Again, just a sample of those essentially, any battery containing device in the body?

Which would include the classic cardiac pacemaker. When we're doing reviews, we always mention that it's not just the pacemakers we're looking for, there are lots of other DH2 hazards as well.

Intrathecal pumps, neurostimulators, some ventricular ventriculoperitoneal shunts are DH2 hazards to cremation there. And that's not always known by the certifying doctors. So that's something that we do see when we're reviewing cases.

And also, fixing nails, which are orthopaedic long bone intramedullary nails, which are expandable and are a DH2 cremation hazard as well. And then lastly, DH3, any radioactive material or other hazardous implant currently present in the deceased. Again, just a small sample, but the classical one there would be sort of brachytherapy seeds that are used for prostate cancer. Other brachytherapy used for other types of cancer and also other radiopharmaceuticals used for cancer, also hyperthyroidism and things like that as well. So just some examples essentially of some hazards there. So just going on to one more example here. You've got a woman aged 65, she's got a past medical history of a pancreatic adeno carcinoma, liver metastases diagnosed one month ago and rapid deterioration since. Deeply jaundiced.

She's had diabetes, type two diabetes for 16 years, a previous STEMI, and she's got a pacemaker in situ as well. She's also got mild asthma and bipolar disorder, which are managed well. She dies at home peacefully from her cancer and the doctor has decided that they're able to issue the certificate here. And they've got a 1A here of progressive liver metastasis with the condition that caused or created that being the adenocarcinoma of the pancreas.

And they've got the histology there as well, which is great. Contributors being the type two diabetes mellitus and the ischaemic heart disease.

And quite rightly, they have ticked the DH2 box there because there is a pacemaker in situ. Very small tip again, staging of cancer shouldn't be included. So TNM scoring or Gleason scoring shouldn't be added to the certificate, but pathology should be. So, adeno carcinoma, squamous cell carcinoma is always good to have on the certificate if you know it.

Yeah, I think I'm going to... Yeah. So, what I'll do is I'm going to hand you over to my colleague, Dr. Conway now, to continue the presentation, and then we should have some time for some questions at the end there. So, Rosie, over to you.

Rosie Conway (RC): Great, thanks Steve. The next bit of the death certificate to think about after you've done the hazards is the attendance. Attendance is not legally defined. But attendance from the CMO guidance is taken as meaning that if you've attended to somebody, and you've looked after them during their illness or looked after them with the condition that has subsequently led to their death. It's taken also to mean that the doctor who's in attendance is familiar with that patient's history and with their investigations and treatment.

So, there are three choices for filling in the attendance box: A1, A2 and A3. So A1 is that you were in attendance and that's easy if you've known the patient and you know them well, then you can easily tick the A1 box. But also, if you're a junior doctor on a ward and you've seen a patient on a ward round, you may not have actually examined them yourself, but you've been involved in their care, you've prescribed for them, you've been on duty out of hours and have had handovers about them and that kind of thing, then you can tick the A1 box.

Similarly, if you're a GP and you have had telephone consultations with that person or prescribed repeat prescriptions for them, then you could tick the A1 box as well. So, it's a pretty loose definition. But if you know them and you've been involved in their care, A1 would be the box to tick. A2 is that you really don't know the patient at all, you haven't been involved in their care, but you still can complete the certificate. But the doctor who was in attendance isn't able to do it. So, the A2 boxes, if you come back from a holiday, somebody's been in the ward, they may have died overnight and you weren't involved in their care, but you got the notes and you chatted to people about how to certify, then you can write the certificate and tick the A2 box. And the A3 box is usually used for when there's been a sudden death. And this would be something that a forensic pathologist might tick on a death certificate of somebody who's had a sudden and unexpected death with really no medical attendance at all. So really if you're a GP, or if you're working in a hospital, you're really going to use the A1 or A2 boxes predominantly.

There'll be very few occasions where A3 would be required. The next bit of the death certificate that we quite often have chats to doctors about, the extra information box. So, this is the bit that says, I may be able to supply the registrar general with additional information, and yes, you may, but also you may not. And actually, the extra information they're looking for in that question is if there's any outstanding results that might change or add some detail to the death certificate that has been written. So, for instance, you might be waiting for histology to come back, toxicology results, microbiology from cultures or genetics and stuff like that that you think, okay, this might be important to add onto the death certificate later, just for statistical purposes.

So, what happens when you tick that extra information box is that about six weeks after the person has died, National Records of Scotland will write a letter called a Medical Inquiry letter to the named consultant or the GP. And they'll ask, what extra information do you have? And as a consultant, I quite regularly used to get these letters and it took me a while to work out why I got them. And it's because my junior colleagues were very helpful and really wanted to be as helpful as possible.

So, they ticked to the box saying, yeah, I'm very happy to supply the registrar general with information, but actually it made me quite a lot of work at the other end. Trying to get the notes back from medical records and go through them to see actually is there actually any extra information that can add detail here to the certificate?

And most of the time there wasn't. So that's quite a common thing that doctors are really helpful people, and they want to do their best for patients. And they tick the box just to be helpful. And actually, you only need to tick it if there's outstanding results there. So, you'll save yourself quite a lot of time if you don't tick that box unnecessarily. Next thing to think about is whether the death needs to be reported to the fiscal. Because there's the box and the MCCD, whether you do it electronically or on paper form to see whether you have reported the death to the fiscal.

If you have reported the death, then you tick that box and it doesn't get reviewed by DCRS, we don't look at certificates that have already been through the fiscal process. So, there is guidance that the Procurator Fiscal, and Crown the Office has issued to us as doctors about the deaths which must be reported to them. And this slide comes directly from the fiscal guidance. So essentially, it's any death which is caused by something unnatural. And this could be for instance suspicious deaths where there's a suspicion of homicide or a possibility of suicide.

Also, deaths from accidents at work and deaths from children from overlaying or suffocation, which are thankfully very rare. But I think the other two in this list are not as well known by doctors as perhaps they should be. And that's drug-related deaths and accidental deaths.

And it's not just drug-related deaths that are due to people using recreational drugs or any illicit drug use or overdoses. It's also including deaths due to adverse drug reactions, which are reportable into the Yellow Card Scheme. And being mindful that there are quite a lot of drugs out there which are so-called Black Triangle drugs, which are under extra surveillance by MHRA.

And those include drugs that we use all the time such as rivaroxaban but also including some of the newer immunotherapy drugs that are used in oncology.

So do check if there are deaths that are related to adverse events and you want to, you feel that you have to Yellow Card that drug, and if the death is due to that drug reaction, then you should be reporting that to the fiscal. The next big category is accidental deaths.

And we pick up quite a lot of certificates that have causes of death on them, which are due to accidents, and they should all be reported to the fiscal no matter how historic they are.

So, for instance, any death due to a fall, and you can imagine that falls are pretty common, particularly in an older population. And if we see fractured neck or femur on a death certificate that's come to us, then it really needs to go to the fiscal if it's due to some trauma. The fiscal also wants to know about some natural causes of death as well as the unnatural ones.

And again, this list isn't exhaustive, but I'll go through it just to give you a flavour of the kind of things that they want from us as doctors. And I've got a link at the end of the slide as well to the fiscal guidance. So, you can have a look at that yourself in your own time because it's a comprehensive document. So first of all, any death due to neglect or fault. And that could be somebody who's had large self-neglect as well, or any fault in any kind of machinery, or any kind of medical fault.

Any sudden or unexpected child death or unexplained perinatal death. And quiet, we don't see many deaths from children fortunately.

But a lot of childhood deaths are very sudden and unexpected and therefore need to be reported. Similarly, any death of a child who's in local authority care or on the Child Protection Register.

Essentially, the fiscal needs to have a report here to make sure something hasn't gone wrong in terms of that safeguarding for that child. As many of you will know, any death that is caused by industrial illness should be reported. And most commonly in Scotland, that would be death from mesothelioma or asbestosis or less commonly known now, pneumoconiosis, as the coal mines have all shut. But the relevance of this is that families may be eligible and can apply for compensation, even after the patient has died. So, the fiscal often will gather evidence to support a civil claim for the family.

Deaths from notifiable diseases that pose an acute and serious risk to public health. And that tends to be outbreaks of disease rather than individual cases of Covid-19. If it's a single case of Covid-19 in a ward that may have contributed to the death, it doesn't necessarily need to go. But if there's an outbreak of Covid-19 in that ward, then that would be something that we would direct you to report to the fiscal about.

And again, in terms of safeguarding and care of people who perhaps are more vulnerable in our communities, any death of a person who has been detained under a section of the Mental Health Act or who's subject to a Community Treatment Order, those need to be reported. And we do have occasional calls, especially for advice from psychiatrists about whether or not a death of a person in their care, how they can certify. And one of the first things we will ask them were they under a section or did they have a CTO?

And similarly, any death in legal custody. So, anybody who is a prisoner or still in legal custody. Any death of those persons is an automatic Fatal Accident Inquiry by the fiscal. So, I know in my role in the hospice, We, not infrequently would have patients who came to the hospice for end-of-life care, having been in custody. And we always made great efforts to have the custodial sentence rescinded so that when they did die, then it didn't need to be reported to the fiscal.

So, yeah. Do think about that. Any deaths which are likely to be subject to an Adverse Event Review. So, if something has not gone smoothly or has gone wrong, or there's an AER about it, or if there's any concern or complaint by relatives, or if there's any concern from staff. So, these things do need to be reported. And I think the thing that pulls all these things together, the things that the fiscal wants to know about, which are natural deaths, the thing that unites them is that they could cause public anxiety. And that's the thing to bear in mind.

So just some examples from our case book. This certificate came through and hadn't been reported to the fiscal. Cause of death here was clearly a subdural haematoma and a subarachnoid haemorrhage. But that was in turn caused by a head injury. So clearly, this is a death from an accident. And the reason for reporting these deaths to the fiscal is that the fiscal will was take a health and safety view to protect further public health. So that's the reason for wanting accidental deaths reported.

This next one here is somebody that has had asbestos exposure historically leading to pulmonary fibrosis and then respiratory compromise, which ultimately led to the death. So, when we did this review, we clearly signposted the doctor to report to the fiscal and the case proceeded to a fiscal post mortem to allow the family to make a civil claim should they wish to do that.

Right, we're going to move on to COVID and spend a bit of time chatting about COVID certification and just to signpost you to new guidance that DCRS has produced on this recently.

So, you should be able to find this on the SAD website. COVID has taken up so much time and effort over the past 18 months and how we certify it is important because we want it to be right. So, the acceptable terms, as Steve mentioned before, we're allowed to use the abbreviations COVID-19 disease or SARS-COVCoV-2 infection. So those are the preferred and acceptable terms that the registrar will accept. As Steve alluded to, if you feel that COVID has either caused or contributed to the death, then it should be on the death certificate. If, however the person had COVID and was completely asymptomatic and died with something else and the COVID was completely unrelated, it doesn't need to be on the death certificate. You only put things that have actually caused or contributed to the death on the certificate. And that is a clinical judgement for you to make.

You still need to consider the hazards to safe disposal. And you need to think carefully about COVID and hazards. We know how long people remain infectious for is uncertain, particularly in people with immune compromise. So, you need to make a clinical judgement about whether this body may pose a hazard to those people who are handling it after death.

So, if you do think there's a hazard and you're concerned about the safety of those onward people then tick the DH1 hazard box. And I think broadly, our advice to you would be, be prudent about that and err the side of caution if you're not sure. So just some examples of COVID certification here. We've got a 64-year-old lady living at home. She's got type two diabetes, hypertension and AF. She developed COVID symptoms five days ago and had a positive PCR test. She became acutely short of breath last night, called 999 and had quite deranged physiology on observation, was taken to ITU on admission, with ARDS type picture, and then subsequently developed multiple organ failure and sadly died four days after admission.

So, there's lots of different ways of certifying in a reasonable way. And I'll just show you this by way of one example of what a reasonable certificate could look like.

So, the doctor completing here has considered that the multiple organ failure was the condition directly leading to the death. And that in turn was caused by the acute respiratory distress syndrome, which was itself caused by the COVID-19 disease.

This doctor has also considered that hypertension and type two diabetes have been contributors. And we know that people with these conditions are more prone to severe COVID consequences.

So that seems very clinically reasonable. The hazards part of the certificate is here. And the doctor, I think, has very wisely ticked the DH1 hazard because this body may well pose a risk to those subsequently handling the body. This person only had COVID for nine days, there's a very good chance they remain infectious. So certainly, the DH1 box. If it hadn't been ticked, we would've been questioning why. And some COVID deaths do need to be reported to the fiscal. And last July, the Lord Advocate issued guidance to us as doctors that we needed to report COVID deaths in people who were resident in care homes when the virus was contracted, and in people who died from COVID, where the virus was contracted in the course of their employment or occupation.

And this was really driven by public anxiety about deaths from COVID in care homes and people like ourselves, healthcare professionals, social care professionals, people working in supermarkets, other key workers may be exposed to COVID as part of their occupation.

So that's the reason for reporting these is that these deaths have caused public anxiety. We need to also think about COVID that is contracted in hospital. And we know that there is surveillance of this ongoing in terms of ARHAI reporting that is ongoing. And there are other sections in the fiscal guidance which are sections 3E and sections 3G, which really pertain to deaths which can cause

public anxiety or where there's family or staff concern or complaint. So do bear that in mind. So just by way of example, we've got a story here of an 87-year-old lady in a care home for the last couple of years with Alzheimer's disease and ischaemic heart disease.

There's sadly been an outbreak of COVID-19 in the care home. She has a positive PCR test and dies six days after symptom onset. And this is a certificate that came through to us for randomization and review. And COVID-19 disease is the immediate cause of death with the Alzheimer's and IHD in part two. And because this lady contracted the virus in the care home, then it needed to be reported to the fiscal and we signed posted signposted the doctor to report.

Okay, so that's all the kind of factual stuff, just a quick run through of how to complete the MCCD, maybe a wee reminder of certifying COVID deaths and just signpost to our new DCRS guidance on that. And a bit of stuff about what you need to send to the fiscal and report to them. So just going to go through the quiz questions, just so you can see whether you were right or wrong and check your knowledge. So does active Hhep B is a hazard? Oh yes. If you imagine, many people have embalming after death and embalming is an invasive vascular procedure, and certainly embalmers wish to know about bloodborne viruses that are active.

So yeah, definitely a hazard, as would be active Hep C and HIV. So, my patient died from hypoxic brain injury after a suicide attempt, should I issue? Nope, definitely not. This is not a natural death. And it comes under that category of unnatural deaths, homicides, potential suicides. So definitely report that one to the fiscal and they may invite you to issue at some point later once they've completed any investigation they wish to make.

Cerebral Cerebrovascular accident is allowed? Nope, no. Steve highlighted the registrar will reject that. So, use stroke if you don't know the kind stroke it is or use cerebral infarct, cerebral haemorrhage and the site of the stroke, if you do know it. So be as specific as you can about certifying the stroke deaths. TNM staging is encouraged?

No, definitely not. So staging is not required and actually shouldn't appear in the death certificate. And also, TNM is an abbreviation sphere.so you’re not allowed it on those grounds either, it'll be rejected.

And filling in the durations is optional. And as Steve explained, each line of the sequence should have a duration with the exceptions of old age and congenital conditions. And this patient died in hospital after being transferred from prison and are still in custody.

Does it need to go to the fiscal? Yes, it certainly does. And it'll be an automatic. Fatal Accident Inquiry. So hopefully that answers your quiz questions.

And here's just a link to our guidance documents, CMO guidance, which is the Bible of how to complete death certificates in Scotland, and a link to the Procurator Fiscal website here, and then a link to the SAD website and also the DCRS learning modules, which we have on TURAS.

So, these will all be posted in the PowerPoint that you can get after the presentation as well. So don't feel you need to scribble them down now, they will be available later for you. That's the last thing I have to say other than here's our contact details. We do give advice to doctors if your phone us, and there's our phone number, or you could email. But yeah, we're always happy to give advice upfront before you write the death certificate. And hopefully hear a friendly voice on the end of the phone to help you work out what's the best thing to do.

So, thanks very much. Thanks for the invitation and over to you, Ken.

KD: So, Rosie and Steve, thank you so much for that. It was really comprehensive but clear. I loved the use of examples and all the way through I just kept thinking, I wish I'd had this webinar 25 years ago when I came out of medical school, it would've been useful because the amount of angst and pain over death certificates when I was a junior doctor, Lots of it.

So, thank you, that was a really, really good presentation. I can see we have a number of questions appearing in the question box. I'm going to hand over to you, Phil, if you want to just start to run through those for us.

Philip Smith (PS): Thank you very much, I'm Phil from the NES Bereavement team. So firstly, I'm going to read a couple of questions we have had coming from the point of registration. First one, someone has asked, I had a case recently where a family said their relative died at 10:05 and the actual out-of-hours doctor confirmed death at 11:30, I put 11:30 as the time of death. At Aon review, I was told I should have used when the family thought they died. Could you clarify?

SM: Yeah, happy to clarify that one. And we did touch on that during the presentation as well, which is good. It's a really good question. And yeah, it's something that we get asked quite a lot and it's something that comes up on our reviews quite a lot. But as I mentioned in the presentation there, the time of death is the time to the best of your knowledge and belief that the patient has passed away. And as I said, the CMO guidance is quite clear that you can use any information that you have on that.

Including information from family members, nursing staff. So, if you have a family member that is fairly clear that their patient passed away at certain time, and someone whether it's one of ours out-of-hours or yourself, then later verifies the death at a later time, you should always go with the time that you feel the patient has passed away. So, you'd go with the earlier time in that case. And yes, that does come up frequently on reviews. Obviously slightly more important when it's nearer the midnight hour because it can actually change the date of death. But it's still important all the same to family as well. They like to have an accurate record there and that's important. So, time passed, not time verified.

PS: Great, thanks Steven. Our other question that came in the at registration -. COVID-19, if a patient had a confirmed infection within 28 days of death, but no obvious ill effects from it, should it be mentioned on the death certificate? In their example, the patient died likely suddenly from an MI on day 14, is the patient added to coverage COVID statistics?

SC: Okay, I can only answer the bit about whether it should appear in the death certificate and if it didn't contribute or cause the death, then no, you don't have to put it on the certificate, but you still need to consider the hazard to safe disposal. I'm not sure about statistics. I'm not the best person to answer that bit about whether they're included or not.

PS: Thank you, Rosie. We had a question coming in regarding the Procurator Fiscal portion of the presentation. Quite often, people forget that a patient's admission after started with a fall at home and having died ought to be referred to the Procurator Fiscal. But often the fall seems fairly unrelated to their eventual death. Can we use our own judgement as to who to refer to the Procurator Fiscal, or should we refer all deaths after a fall?

SM: Yeah, I'm happy to take that one. Essentially, as I mentioned may be nearer the start of the presentation, it is very much a doctor's judgement as to what has caused or contributed to the death.

Any fall or accident that has caused or contributed to the death should be reported to the Procurator Fiscal. I suppose we gave examples here. I know Rosie mentioned the fractured neck or femur. So, say someone has a fractured neck or femur. They're in a nursing home, they're getting about okay, mobility's not too bad. They're sort of frail but generally doing okay, they fall, fracture their neck or femur, they're admitted to hospital, they have it repaired, but they're never really quite the same, mobility is poor, they deteriorate and they pass away. In that kind of history, it would seem very reasonable that that fractured neck or femur did contribute to the death. Whether it's in part one or part two, it doesn't matter. It sounds like it contributed to the death and therefore it should be reported to the fiscal. You could have a similar scenario where perhaps a very frail person in a nursing home had a fall and fractured their humerus say seven days before death.

However, this was going to in the lead up to them being very frail, they were near end of life at this time. And it was felt by the doctor that it actually didn't have anything to do with the death. So i.e., the fractured humerus didn't contribute to the death, it didn't accelerate the death and had they had the fractured humerus or not, they would've died at the same time.

The doctor may feel at that point then that it didn't contribute to the death. And if that is the case, then it's not reportable to the Procurator Fiscal because it's not going to appear in the death certificate, yeah. So, in answer to the question, yes. It's very much a doctor's judgement as of to whether or not it caused or contributed to the death.

PS: Thanks, Steven. To our attendee, who asked that, I hope that helps. But please, if you have any follow-up questions, feel free to put those into... Our next attendee thinks they might have quite a basic question, but they ask: if they're reporting a death to the Procurator Fiscal, can they still complete an MCCD? For instance, in the case of mesothelioma?

RC: Shall I take that one, Steve?

SM: Yes, absolutely.

RC: So, if you have a death that's reportable to the fiscal, don't fill the death certificate in until you've had an invitation to do so from the Procurator Fiscal after they've completed their investigations. So, the fiscal will invite you to issue. So, you need to think about what you might put on the certificate, but you shouldn't issue it until the fiscal has asked you to do that.

PS: Great, thank you, Rosie. Our next person says they've previously had common advice that failures, e.g., heart failure, are inappropriate as causes of death. They noticed that multi-organ failure was used in one of the examples MCCDs. Could you shed any light on this?

SM: I'm happy to take that one. They're quite right. It's a very good question again, actually. That's something that comes up in reviews and there is a part in the CMO guidance that mentions this as well. It's not so much that the organ failure shouldn't appear on the death certificate, it's more the fact that if it does appear in the death certificate, it is advisable to have the condition that caused that organ failure. So absolutely fine to have multi-organ failure at one 1A or you know, left ventricular failure on the certificate, congestive cardiac failure. As long as, to the best of their ability, they're able to then put under that what caused that organ failure.

So you may have a certificate with 1A of congestive cardiac failure, and if that is there on its own, then that's certainly not ideal unless you really have no idea what caused that congestive cardiac failure. If you've got one that's got congestive cardiac failure at 1A, at 1B it's felt that in all likelihood, there was the ischaemic cardiac heart disease that caused that congestive cardiac failure, then that's absolutely fine.

And it's fine to have organ failure on the certificate in that regard. I don't know if there's anything else, Rosie, you want to add about that or?

RC: Just that, yeah, having organ failure alone isn't ideal. Try to think of why they have had the organ failure, because actually that's the underlying cause of death.

PS: Thanks, Steven and Rosie. We've got just a couple more. Hopefully we can get to them. Our next attendee asks: if you haven't seen the patient or spoken to them for a few months, but knew them and e.g., they had a good history of chest pain and collapse, can you still use A1 or do you have to have seen the patient in the last month?

RC: Okay, I'll take that one. You don't need to have seen the patient within the last month in Scotland, so attendance is not legally defined. And if you've seen them previously, then you would be fine to tick the A1 box because you've likely looked after them in their and the conditions that have led them to have their acute MI or whatever. So yeah, A1 would be fine.

PS: Great, thanks. We've got a couple of other questions that we'll address by email after the session. So, we'll make sure not to miss those. We'd really be grateful if you could complete the poll just to indicate how today's session might have helped you with your confidence in the MCCD.

SM: Oh, great.

RC: Wow.

KD: That's a significant change there. Well done guys, yeah. So, we've had a real shift down towards predominantly four and five, which is excellent. I have to say, I wasn't able to vote actually. I assume it's because I'm an organiser. But for me it's been years since I did a death certificate and I'm feeling fine five coming out of it, because it was... Not that it matters, I probably wouldn't have to fill one in ever again.But that's really encouraging.

SM: Very kind, Ken. Very kind.

RC: You can always phone us for advice, Ken, if you're stuck.

KD: So just final comments before we go off. The final thing to say is that the Events page on the Support and Around Death website has more information about future webinars throughout the rest of the year and into next year. And, if you wish to listen to previous webinars, you can find them on the SAD website. So really what's left for me is to say thank you to both Rosie and Steven. That was a fantastic presentation. Really clear but covered an awful lot of information. And as we can see by that poll, people are feeling a lot more confident around death certificates. So, I hope we'll see all those issues that come to DCRS are just going to disappear. Everybody's going to be carefully perfectly accurate. Thank you very much both, really appreciate that. It was really helpful.

SM: Thank you for having us. Thank you.

RC: Yeah. Thank you.

KD: Thank you those of you on the call and for asking questions and hopefully see you in future webinars. So, thanks very much, everybody.

The film was produced in October 2021 and can be found at www.sad.scot.nhs.uk or https://vimeo.com/669353057

For more information visit www.sad.scot.nhs.uk or contact supportarounddeath@nes.scot.nhs.uk