



Factsheet 29: Medical certificates of cause of death (MCCD)

Key considerations for reviewers

- It is common for there to be a sequence of conditions that lead to a person's death. These should all be recorded on the person's Medical Certificate of Cause of Death (MCCD)
- You will need to provide the full sequence (described in sections 1a, 1b, 1c, 1d, 2 of the MCCD) in your review of the person's death.

Introduction

In England and Wales, compulsory national registration of deaths began in 1837. The Births and Deaths Registration Act 1953 requires registered medical practitioners to certify the cause of death of deceased patients. This is in addition, and separate to, the certification that a person is deceased.

Medical Certificates of Cause of Death (MCCD) (sometimes called 'Cause of Death certificates') are the permanent legal records of deaths. Families require a MCCD to be able to register their relative's death and to confirm the cause of the death. In addition, analysis of MCCDs is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for medical research and health services, planning services, and assessing the effectiveness of those services.

It is the doctor who has cared for the person during the illness that led to their death and is familiar with the person's medical history, investigations and treatment, who would usually complete the MCCD. The certifying doctor should also have access to relevant medical records and the results of any investigations. In hospital, it is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. In general practice, more than one GP may have been involved in the person's care and so be able to certify the death.

If the cause of the person's death is not known, it must be referred to the coroner. Other deaths that must always be referred to the coroner before they can be registered include:

- Deaths which may be due to accident, suicide, violence, neglect (by self or others) or industrial disease.
- Deaths occurring during an operation, or before full recovery from an anaesthetic.
- Deaths occurring in, or shortly after release from, police or prison custody or other form of state detention, including under a deprivation of liberty (dols) order if the death occurred before 3rd april 2017.
- If there is no doctor who attended the deceased available to certify, or if the certifying doctor did attend the deceased, but has not seen them either within 14 days before death, or after death.

The doctor should always discuss the case with the coroner if at all uncertain whether he or she should certify the death.



When a death is referred to the coroner, it is up to the coroner to decide whether or not it should be investigated further. The coroner may request a post-mortem examination of the body to ascertain the cause of death, or may require that an inquest is opened to investigate the death further.

The Medical Certificate of Cause of Death

The Cause of Death Certificate is set out in two parts, in accordance with World Health Organisation (WHO) recommendations.

Part 1 describes the immediate cause of death, and then works back in time to the disease or condition that started the process. 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. This initiating condition, on the lowest line of Part I will usually be called the *underlying cause of death*. The underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

WHO defines the underlying cause of death as:

- “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”.

In some cases, a single disease may be wholly responsible for the death. In this case, it would be entered on line 1a and this would be considered the underlying cause of death.

If a person had more than one disease or condition that was compatible with the way in which he or she died, but the doctor cannot say which was the most likely cause of death, each of these causes should be written on the same line and with “joint causes of death” in brackets.

From a public health point of view, preventing the underlying cause of death is likely to result in the greatest health gain. Most routine mortality statistics are based on the underlying cause, and it is this cause of death that is usually used to determine priorities for health service and public health programmes and for resource allocation.

Part 2 of the Cause of Death certificate is used to record other significant diseases, conditions or illnesses which contributed to the occurrence of the death, but were not part of the main sequence leading to the death. Part 2 should not be used to list all the conditions that were present at death.

Some examples of how you might see the cause of death described on a Cause of Death certificate (taken from the Confidential Inquiry into premature deaths of people with learning disabilities)

Example 1:

- 1 a) Congestive Cardiac Failure
- b) Atrial Septal Defect
- 2. Down Syndrome

Example 2:

- 1 a) Sepsis
- b) Aspiration pneumonia
- 2. Cerebral palsy

Example 3:

- 1 a) Pneumonia
- b) Carcinomatosis
- c) Carcinoma of lung
- No Part 2 contributing cause of death



Despite the clear guidance provided by the WHO about how causes of death should be reported, there is a lack of consistency in recording whether or not a person had learning disabilities on the Cause of Death certificate. This inconsistency occurs in two directions:

- i. inaccurately listing learning disabilities as a cause of death
- ii. omitting to mention that a person had learning disabilities

There are a number of reasons for such inconsistencies, including:

1. Multiple coding options for learning disabilities.
2. Inconsistencies in interpreting contributing causes of death, with medical professionals deeming the fact that a person had learning disabilities to be relevant, but being unable to record it anywhere other than in Part 2 as a contributing cause of death.
3. How well the deceased person was known to the certifying doctor, and the availability of medical information to them.

Future reforms

From April 2018 The Medical Examiner system is being rolled out. All MCCDs of people who die in acute care (hospitals) will be confirmed by local Medical Examiners once they are operational in a particular area. Overtime, this will extend to deaths in other settings too. This will strengthen safeguards for the public and ensure that the right deaths are referred to a coroner.

The sequence of events following a death where a Medical Examiner is involved is:

1. The medical examiner scrutinises the MCCD and the medical records of the deceased.
2. A medical examiner may determine that the MCCD appears to be incorrect. This would be discussed with the attending doctor, and agree any changes that may need to be made.
3. The medical examiner or a medical examiner's officer will discuss the cause of death with a member or representative of the family of the deceased – 'the informant'. This is an opportunity for any questions or concerns about the cause of death to be raised. If there are no concerns to be addressed then the medical examiner will prepare and sign a notification stating the confirmed cause of death.
4. The notification includes the name of the informant – the person with whom the cause of death has been discussed – their relationship to the deceased and the date and time of the discussion. The notification must be signed by the informant, to confirm that the discussion has taken place, before registration of the death can be completed.
5. The notification will be given to the attending doctor and the registrar that the MCCD is confirmed and can be issued to the informant.
6. The registrar compares the MCCD and the notification, ensures the notification is signed by the informant, and registers the death.

Medical examiners have powers to report matters of patient safety to the local clinical governance team for prompt action. This will improve safety in the NHS, allowing easier identification of trends and unusual patterns, and enable local learning and changes to practise and procedures.

Additional information



Office for National Statistics (2010) Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales. https://www.gro.gov.uk/Images/medcert_July_2010.pdf

Department of Health and Social Care (2016) Guidance An overview of the death certification reforms <https://www.gov.uk/government/publications/changes-to-the-death-certification-process/an-overview-of-the-death-certification-reforms>