



Dear Colleague

GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH (MCCD) AND ITS QUALITY ASSURANCE

Purpose

1. This composite letter provides you with information regarding several areas as below, to avoid sending individual and repeated CMO letters

- Updated joint guidance from the Scottish Government and the National Records of Scotland (NRS) - in paragraph 2
- Updated Crown Office and Procurator Fiscal Service (COPFS) guidance for doctors to report certain deaths to the Procurator Fiscal (PF) - in paragraph 4
- Guidance, attached in the **Annex**, on the new quality assurance system of scrutiny of the MCCDs which commenced on 13 May 2015;
- Subsequent legislation - in paragraph 6
- and
- Implementation of eMCCD in hospitals (paragraphs 10 and 12)

2. As you are aware, the accurate completion of the Medical Certificate of the Cause of Death (MCCD or Form 11), by the medical practitioner to the best of his/her knowledge and belief, is a statutory requirement for all registered doctors and licensed to practice in the UK. COPFS has been consulted about the joint CMO/NRS guidance for doctors completing MCCD and its quality assurance.

3. Details of the changes to the MCCD and information about electronic completion of MCCDs were provided in the CMO letter of 25 June 2014, which can be accessed through the link below [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)16.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)16.pdf)

4. At the same time, COPFS also consulted with the medical profession while developing its own guidance on reporting certain deaths to the PF. The COPFS document called “ [Reporting Deaths to the Procurator Fiscal- Information and Guidance for Medical Practitioners](#)” is intended to provide a clear and concise guide to

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SGHD/CMO(2018)11

Addresses

For action

NHS Boards and Special Health Boards Medical Directors to cascade to all doctors

For information

Directors of Public Health, NHS Boards
Chief Executives, NHS Boards
NRS
COPFS
SFIU
Central Legal Office
Care Inspectorate
MDDUS
MPS
MDU
GMC
BMA Scotland
Academy of Medical Royal Colleges and Faculties in Scotland
Hospices
Private hospitals
Police Scotland

doctors in deciding whether a death requires to be reported to the PF and the process to be followed.

Background

5. In 2007, the Scottish Government established the Burial and Cremation Review Group to review the Cremation Acts of 1902 and 1952 (and the Cremation (Scotland) Regulations 1935, as amended), and the Burial Grounds (Scotland) Act 1855. The Group's report in October 2007 made several recommendations to the Scottish Government on how to update and modernise the legislation in order to better serve the needs of the people of Scotland.

6. As a consequence, the Certification of Death (Scotland) Act 2011 ("the 2011 Act") was introduced to update the first phase of the Certification of Death process in Scotland. Details of the aims of the legislation can be accessed through the website below.

<http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

Work is ongoing on a second piece of legislation, [Burial and Cremation \(Scotland\) Act 2016](#), to address the remaining recommendations of the Burial and Cremation review Group relating to burial, cremation, disposal of remains and other aspects of the funeral processes. This available at: <http://www.gov.scot/Topics/Health/Policy/BurialsCremation/BurialandCremation-Scotland-Act2016>

7. On 20 March 2014 the Chief Medical Officer issued a letter explaining the initial actions to be taken to implement the Certification of Death (Scotland) Act 2011, through Health Board Implementation Leads. This is available at: [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)08.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)08.pdf)

8. Cremation forms B and C **are not required** in Scotland, from the date the Certification of Death (Scotland) Act 2011 came into effect on the 13 May 2015, irrespective of where the death occurred. Following re-prescription, the new MCCD was implemented on 6 August 2014.

9. After registering the death, and before being able to proceed with a burial or cremation, the next of kin gets a certified copy of the register entry, called the "Certificate of Registration of Death", (also referred to as Form 14 and sometimes incorrectly called the "death certificate"), which includes an exact copy of the cause of death information given by the certifying doctor. The Scottish Form 14 is also sufficient to allow cremations in other parts of the UK.

Action

10. We would be very grateful if the attached national guidance, which **replaces** the previous guidance of 29 September 2009 (SGHD/CMO(2009)10) and 18 October 2011 (SGHD/CMO(2011)13), and **updates** the guidance of 16 October 2014 (SGHD/CMO(2014)27, could be circulated widely among medical staff within your Health Board area. NHS Education Scotland (NES) has produced a summary version of the detailed guidance, available at: http://www.nes.scot.nhs.uk/media/2736701/mccd_power_point.pdf

11. Local Implementation Leads in the Health Boards are requested to begin preparations for the phased implementation of the eMCCD in hospitals. The implementation is being supported by NHS National Services Scotland, who will contact Implementation Leads to discuss roll-out and Implementation Lead co-ordination with the Trak Teams in their Boards. GPs are expected to use eMCCDs wherever possible and paper based MCCDs in exceptional circumstances only, where business continuity plans are initiated.

Thank you very much for all your hard work in improving the quality of care in this area.

Yours sincerely

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**GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATE OF
CAUSE OF DEATH (MCCD) AND ITS QUALITY ASSURANCE**

**ADVICE FROM THE CHIEF MEDICAL OFFICER AND NATIONAL RECORDS OF
SCOTLAND**

THE SCOTTISH GOVERNMENT

SEPTEMBER 2018

GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH AND ITS QUALITY ASSURANCE

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GUIDANCE FOR DOCTORS COMPLETING MEDICAL CERTIFICATES OF THE CAUSE OF DEATH (MCCD or Form 11)

1. THE PURPOSES OF DEATH CERTIFICATION

Death certification serves a number of functions. A Medical Certificate of Cause of Death (MCCD) as in **Annex 1**, providing the required information to the best of the medical practitioner's knowledge and belief, is a statutory requirement. This provides a permanent legal record of the fact of death and enables the family to register the death, make arrangements for the disposal of the body, and settle the deceased's estate. Timely and accurate completion of MCCDs is of great help to the bereaved families and friends as it reduces undue additional distress at an extremely difficult time.

Information from MCCDs is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by **underlying cause** is important for monitoring the health of the population, designing and evaluating public health interventions, recognising priorities for health services and medical research, planning health services, and assessing the effectiveness of those services. Data from the MCCDs are extensively used in research into the health effects of exposure to a wide range of risk factors through the environment, work, medical and surgical care, and other sources.

Following a death, the "informant", [who is the person who registers the death](#)¹, and who may be the next of kin or one of a number of different persons qualified to fulfil this role, is provided with the MCCD. They must take the MCCD to the registrar's office to register the death within 8 days of the death being verified or [21 days for registration for a stillbirth](#)². The MCCD must be provided [within 2 to 7 days of the death](#)³, if the death is not reported to the Procurator Fiscal (PF). In the case of a stillbirth, which is considered a "birth" in legislation, the certificate should be provided within 7 days. After registering the death, the next of kin gets a certified copy of the register entry, which includes an exact copy of the cause of death information given by the certifying doctor, as well as the "Certificate of Registration of Death", (also referred to as Form 14 and sometimes **incorrectly** called the "death certificate"). This

¹ <https://www.mygov.scot/register-death/>

² <https://www.nrscotland.gov.uk/registration/registering-a-stillbirth>

³ <https://www.legislation.gov.uk/ukpga/1965/49/contents>

is handed to the funeral director, or burial and crematoria authorities in the absence of a funeral director. The certified copy of the register entry provides them with an explanation of how and why their relative died. It also may provide the family with important information about conditions, which may be important for their own health and that of future generations. For all of these reasons it is extremely important that you, as the certifying doctor, provides clear, accurate and complete information about the diseases or conditions that caused your patient's death, as well as fully completing the supporting administrative data required on the MCCD and outlined in section 7 of this guidance. In some circumstances, the MCCD may be provided by another doctor in the team, with knowledge of the deceased and/or access to the relevant clinical records as described in Chapter 3.

In Scotland, since May 2015, burial or cremation cannot go ahead without registering the death. In some cases the funeral needs to be expedited for religious or other reasons. [Guidance for the provision of MCCD out of hours](#)⁴ (weekends and public holidays only), in exceptional circumstances is available via the link below.

<https://www.gov.scot/Resource/0051/00517435.pdf>⁵

GMC's guidance also expects doctors to be honest and trustworthy when completing or signing forms, taking reasonable steps to check that the information is correct and not false or misleading. Relevant information should not be deliberately left out. A link to the [GMC Good Medical Practice](#)⁶ guidance (particularly paragraph 71).

The MCCD is a legal document and the information provided in it should be accurate to the best of your knowledge and belief.

The 8-digit serial number on each MCCD is made up of a unique seven digit sequential serial number (from the left, digits 1-7) and an additional eighth "check" digit last number on the right. This last digit in the serial number is a random check digit generated to ensure each form is unique. This final eighth digit should be ignored when comparing serial numbers: for example, the ordering of the serial numbers within books (and tracked by range of 7-digit serial numbers, which is printed, on the book cover) are sequential when the final check digit is ignored. Any final "check digit" which is an alphabetic character (such as 'X') is also part of the randomly-generated check digit function, and can safely be ignored when

⁴ http://www.gmc-uk.org/guidance/good_medical_practice.asp

⁵ <https://www.gov.scot/Resource/0051/00517435.pdf>

⁶ https://www.gmc-uk.org/guidance/good_medical_practice.asp

matching the first 7 digits of the 8-digit serial numbers on the forms to the range of 7-digit serial numbers on the book cover. This digit is currently not included in the “Record of Issue” section. The MCCD is a two sided form with the serial number currently not included on both sides. If faxes are used, caution should be exercised while faxing as the two sides may be inadvertently separated and/or combined with incorrect pages. Therefore, the serial number printed on one side of the form must also be copied to and handwritten on the second side of the form. An eMCCD produced and printed from SCI Gateway will have the serial number on both pages of the document.

Healthcare Improvement Scotland (HIS) has developed some [educational resources](#)⁷ to assist in the completion of the MCCD.

NHS Education for Scotland (NES) has produced educational resources to support both certifying and non-certifying staff to implement the new scrutiny arrangements for death certification and registration in Scotland, which were enacted on 13 May 2015.

<http://www.scotlanddeanery.nhs.scot/your-development/death-dying-and-bereavement/medical-certification-of-cause-of-death-mccd/>⁸

This CMO guidance is also available from the [Certification of Death \(Scotland\) Act 2011](#)⁹ website.

Information on the Management of Deaths in the community in hours and out of hours is available from the [CMO/COPFS/Police Scotland guidance](#).¹⁰

Information to register the death is available from the [National Records of Scotland \(NRS website\)](#)¹¹.

Additional information regarding good medical practice is available from the The [General Medical Council](#) ¹²(GMC) website.

⁷http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/educational_support.aspx

⁸<http://www.scotlanddeanery.nhs.scot/your-development/death-dying-and-bereavement/medical-certification-of-cause-of-death-mccd/>

⁹ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

¹⁰ [http://www.sehd.scot.nhs.uk/cmo/CMO\(2016\)02.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2016)02.pdf)

¹¹ <https://www.nrscotland.gov.uk/registration/registering-a-death>

¹² http://www.gmc-uk.org/guidance/good_medical_practice.asp

Legislation for the MCCD is from the powers in the [Registration of Births, Deaths and Marriages \(Scotland\) Act 1965](#)¹³.

Additional MCCD forms can be ordered directly from your Local Implementation Lead, who contacts NRS to arrange supplies. NRS' Local Organisation Unit (-LOU) can be contacted on the following details for help with questions about the Form 11:

E-mail: lou@gro-scotland.gsi.gov.uk

Telephone: 0131 314 4462

2. CHANGES TO DEATH CERTIFICATION

The [Certification of Death \(Scotland\) Act 2011](#)¹⁴ is intended to improve the quality of MCCDs through quality assurance of the MCCD, undertaken by an independent medical review system (Death Certification Review Service – DCRS), comprising a team of Medical Reviewers (MRs), a Senior Medical Reviewer (SMR) and Medical Reviewer's Assistants (MRAs).

The aims of the legislation are:

- To implement a new death certification system in Scotland, which introduces a single system of independent effective scrutiny, applicable to all deaths, except stillbirths and those that require to be reported to the PF;
- To improve the quality and accuracy of MCCDs;
- To strengthen clinical governance in relation to deaths; and
- To provide improved public health information.

The changes in the legislation also mean that neither burials, cremations, nor any other method of funeral can go ahead without prior registration of the death.

Following the implementation of the Certification of Death (Scotland) Act 2011 (on the 13 May 2015), there are two levels of random independent reviews of the MCCD

Level 1 - a basic shorter review, currently of 10% of all deaths

Level 2 - a comprehensive review, of at least 1,000 deaths per year, with additional reviews for cause such as those requested by "Interested Persons" as described in legislation and by

¹³ <http://www.legislation.gov.uk/ukpga/1965/49>

¹⁴ <http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>

MRs/SMR themselves (see **Annex 2, section 8**) i.e. currently about 1,000 deaths (around 2%) per year.

The MCCDs for review are selected at random by NRS at the time that the death is registered by the informant. Where available, an electronic MCCD can be completed and will be automatically transferred to NRS. This reduces the time taken to complete registration, as it enables the eMCCD's to be selected for review at the time of completion. You are required to complete the MCCD promptly for everyone, as death registration must be finalised before the funeral arrangements can proceed. It is particularly important for those cases randomly selected for review as death registration cannot be undertaken until the review process has been completed, unless [Advanced Registration](#)¹⁵ has been granted. A Level 1 review will be completed normally in 1 working day, which includes the time taken to access the necessary information and contact the certifying doctor. The expectation is that a Level 2 review will be completed in 3 working days, although the actual time spent on the review itself will be much less. If the certifying doctor is not available, another member of the clinical team with knowledge of the deceased and/or access to the relevant clinical records can be contacted. The MCCD can only be changed by the certifying doctor. In exceptional circumstances, if the certifying doctor is not available for a significant period, another doctor (see Section 8) can provide a Replacement MCCD. Sometimes the MR may agree to expedite the review, when requested to do so by the [relatives where religious, cultural, compassionate, or practical criteria are satisfied](#)¹⁶. An MR, following consideration of a request by an ["Interested Person" such as a family member](#)¹⁷, can also select an MCCD for review. **Details are included in Annex 2.**

When the Certification of Death (Scotland) Act 2011 was implemented, it also included the removal of the statutory cremation forms B and C, as well as the statutory scrutiny role of Crematoria Referees. From that time, B and C cremation forms have not been required in Scotland, wherever the death may have occurred (in Scotland or in another country). The Scottish Form 14 is also sufficient to allow cremations in other parts of the UK.

3. WHO SHOULD CERTIFY THE DEATH?

¹⁵

http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information/advance_registration.aspx

¹⁶ [http://www.sehd.scot.nhs.uk/dl/DL\(2015\)08.pdf](http://www.sehd.scot.nhs.uk/dl/DL(2015)08.pdf)

¹⁷ "Interested Person" such as a family member

When a patient dies, 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 and so is familiar with the patient’s medical history, investigations and treatment. The certifying doctor should also have access to relevant clinical records and the results of investigations. **There is no provision under current legislation to delegate the statutory duty of providing an MCCD to any non-medical staff.**

There are circumstances where it is not possible for the doctor, who was in attendance, to provide the certificate (in this case “box A2” should be ticked), or no doctor was in attendance (in this case the relevant “box A3” should be ticked). In these circumstances, another doctor in the team, with knowledge of the deceased and/or access to the relevant clinical records, can complete the MCCD. MCCDs completed by a pre-registration doctor in training (FY1), require the involvement of a senior doctor. The Consultant/Specialist in charge of the patient’s care must also be made aware of all deaths, which result in a report to the PF. Wherever possible and practical, a member of the team who has knowledge of the deceased should complete the MCCD e.g. the day team in a hospital.

Discussion of a case with an experienced colleague may help to clarify issues related to the completion of the MCCD. Alternatively, since the full implementation of the Certification of Death (Scotland) Act 2011, MRs can be another source of advice.

In hospitals, there may be several doctors in a team or several teams caring for the patient before death. The Consultant/Specialist in charge of the patient's care is ultimately responsible for ensuring that the death is properly certified. Any subsequent enquiries about the patient, such as results of ante-mortem or post-mortem investigations, will initially be addressed to you as the certifying doctor. If you are not available then the Consultant/Specialist in charge of the patient’s care will be contacted.

In general practice, more than one GP may have been involved in the patient’s care and so will be able to certify the death. If not, the doctor with access to the relevant clinical records can complete the MCCD.

Pathologists completing the MCCD should tick “box A2 or A3” as appropriate.

In the UK, the MCCD of the country, where the patient died and where the death will be registered, should be used.

4. REPORTING A DEATH TO THE PROCURATOR FISCAL

The Procurator Fiscal (box PF) has a duty to investigate certain deaths, such as those, which are sudden, suspicious, accidental and/or unexplained. The categories of deaths, which should be reported to the PF, are contained within the PF guidance [“Reporting Deaths to the Procurator Fiscal, Information and Guidance for Medical Practitioners”](#)¹⁸.

Contact details for the Scottish Fatalities Investigations Unit (SFIU) teams of the Crown Office and Procurator Fiscal Service (COPFS) to whom a death should be reported are provided within the above guidance.

Tick the box “Procurator Fiscal (PF)”, if you or your colleague have **reported** the death to the PF according to the [PF guidance](#)¹⁹. Please ***do not tick the box if you have consulted the PF only for advice, and following discussions with the PF it has been agreed that the circumstances of the death in question are not reportable. However, please ensure that the discussion with the PF is recorded in the clinical records of the deceased patient. Be very clear whether or not you have formally reported the death to the PF. If you have, and even if you have agreed to produce an MCCD with them, then you should tick the box.***

For the purposes of the PF, a death should only be reported if it falls into one of the reportable categories. The PF does not need to be told about all deaths, which occur when the deceased is under 18 years of age – only those in the categories listed in the PF guidance. For example, you should report an accidental death whether the deceased is 15 years or 25 years of age.

Please also note that in the context of reporting to the PF, there is a specific requirement regarding children up to the age of 18 years i.e. “Any death of a child or young person under the age of eighteen years who is ‘looked after’ by a local authority.....should be reported to the Procurator Fiscal”.

¹⁸<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

¹⁹<http://www.copfs.gov.uk/publications/deaths>

Regarding infectious diseases, it is only those deaths, which pose an acute and serious public health risk that require to be reported, **not all notifiable infectious deaths** *per se*. This may include deaths, which are “sudden”, or those, which could cause “public anxiety” as in the [PF guidance](#)²⁰.

Community Health Index (CHI) number and the Health Board where death occurred also need to be included the form while reporting a death to the PF.

If you do have to make a formal report to the PF, you should provide clinical and other relevant information similar to a referral being made to another clinician (the consultant pathologist in this case). If there is enough information in your report this will assist the pathologist, as he/she may not require sight of the medical records, and in some cases, may allow the pathologist to ‘view and grant’ rather than carry out an invasive autopsy. This speeds up the process for the bereaved family and avoids unnecessary autopsy.

5. SEQUENCE LEADING TO DEATH, UNDERLYING CAUSE OF DEATH AND CONTRIBUTORY CAUSES – GENERAL PRINCIPLES (PART C OF THE MCCD)

The MCCD is set out in two parts. You are asked to start with recording the immediate, direct cause of death on line I(a), then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence.

Usually, 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. However, sometimes what is written on the lowest completed line will have created the circumstances for (rather than caused) the other conditions. For example, if someone had a fall, went to hospital, contracted a healthcare associated infection and died, one would say that the accident initiated the train of morbid events leading to death (even though the fall *per se* did not cause the infection).

This initiating condition, on the lowest line of part I, will usually be selected as the **underlying cause of death**. 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**”.

²⁰<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

From a public health point of view, preventing this first disease or injury will result in a greater health gain than treating a subsequent direct/immediate cause of death. The causes of death should be described succinctly i.e. naming relevant diseases, conditions or events which can be coded by NRS using International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (currently ICD10 as ICD 11 is being developed) codes, as well as providing relevant information to the family about the cause of death. Avoid long lists on the same line: for example, you should use a separate line for each condition and avoid recording both a cause and its consequence on the same line. Rarely, two conditions can be given on the same line if it impossible to say which the main cause of the condition, mentioned in the line above, was (see section 5.2 below). The “approximate interval” boxes should indicate time intervals, rather than relative time intervals such as “x” days earlier/later than the condition mentioned in the line above or below. Importantly, write legibly (if not using the electronic version of the MCCD), and avoid abbreviations (See section 5.8).

Examples of cause of death section from MCCDs:

Cause of Death

This is the disease or condition that you believe to be the underlying cause and which usually appears in the lowest completed line of part I

Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health service and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

You should also enter any other diseases, injuries, conditions, or events that you believe contributed to the death, but were not part of the direct sequence, in part II of the certificate. Something “contributed to” the death if it made the person more vulnerable to the fatal condition, or weakened the person so that death occurred sooner than otherwise would have been the case. For example, someone with diabetes mellitus who died of lung cancer might have died sooner than would have been the case if he/she did not have diabetes mellitus. If so, diabetes mellitus should be recorded in Part II as contributing to death.

However, do not enter any diseases, injuries, conditions or events that did not, in your view, contribute to the death. For example, if someone with osteoarthritis died of lung cancer, it is unlikely that osteoarthritis would have contributed in any way to death, so it should not be mentioned in part II.

Where appropriate, in parts I or II, you should give information about clinical interventions, procedures or drugs that may have led to adverse events.

The information in this section is transcribed by the registrar into an electronic system, which allows 69 characters per line, including spaces. In part I, there are 4 lines, making for 276 characters in total for I a to I d. In section II there are 3 lines, which together make 207 characters.

Durations

It is important to record, in the boxes on the right-hand side of the form, the approximate interval between the onset of each disease, injury, condition or event and death. This information provides confirmation that the entries are in the correct order, and may be essential for the accurate classification of the causes of death. Ticking the box, without the specified time intervals, will not be acceptable. The interval should be given for all conditions, in both part I and part II. It will not be acceptable to leave this blank, except for Old age, which does not require an interval. Genetic and congenital conditions that were present at birth do not require an interval to be given. You should clearly state that they were present at birth on the MCCD.

Example A:

I		Approximate interval between onset and death		
		Years	Months	Days

Disease or condition directly leading to death	(a) Intraperitoneal haemorrhage			1
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or a consequence of) (b) Ruptured metastatic deposit in liver			1
	due to (or a consequence of) (c) Metastases to liver		6	
	due to (or a consequence of) (d) Primary adenocarcinoma of ascending colon	2		

II Other significant conditions contributing to the death, but not related to the disease or condition causing it	Type 2 diabetes mellitus (mild obesity related)	20		

The colon cancer on line 1(d) led directly to the liver metastases on line 1(c), which ruptured after 6 months on line 1(b), causing the fatal haemorrhage on 1(a). Adenocarcinoma of the colon is the underlying cause of death. Type 2 diabetes contributed to the death but was not the direct cause of death.

Example B:

I		Approximate interval between onset and death		
		Years	Months	Days

Disease or condition directly leading to death	(a) Cerebral infarction			1
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or a consequence of) (b) Thrombosis of basilar artery			2
	due to (or a consequence of) (c) Cerebrovascular atherosclerosis		6	
	due to (or a consequence of) (d)			

II Other significant conditions contributing to the death, but not related to the disease or condition causing it				

In subsequent examples, to save space, the layout of the MCCD has not been reproduced and the information about the interval between onset and death is not shown.

In some cases, a single disease may be wholly responsible for the death. In this case, it should be entered on line I(a) and the rest of parts I and II can be left blank.

Example C:

1a. Meningococcal septicaemia

Meningococcal septicaemia is the underlying cause of death.

5.1 More than four conditions in the sequence

The MCCD has 4 lines in part I for the sequence leading directly to death. If you want to include more than 4 steps in the sequence, you can do so by writing more than one condition on a line, indicating clearly that one is due to the next. The duration of the first condition only on the line will be recorded on the electronic system Forward Electronic Register (FER) used by NRS.

Example:

- Ia. Post-transplant lymphoma*
- Ib. Immunosuppression*
- Ic. Renal transplant due to Glomerulonephrosis*
- Id. I Type 2 diabetes (severe insulin resistant) mellitus*

II. Recurrent urinary tract infections

Type 2 diabetes (severe insulin resistant) with renal complications is the underlying cause.

5.2 More than one disease may have led to death

If you know that your patient had more than one disease or condition that was compatible with the way in which he or she died, but you cannot say which was the most likely cause of death, you should include them all on the certificate. They should be written on the same line and you can indicate that you think they contributed equally by writing “joint causes” in brackets.

Example A:

- Ia. Cardiorespiratory failure*
- Ib. Ischaemic heart disease and chronic obstructive airways disease (joint causes)*

II. Osteoarthritis

Example B:

- Ia. Hepatic failure*
- Ib. Liver cirrhosis*
- Ic. Chronic hepatitis C infection and alcoholism (joint causes of death)*

Where more than one condition is given on the lowest used line of part I, NRS will use the internationally agreed mortality coding rules in ICD10 to select the underlying cause for routine mortality statistics. This will normally be the first cause that is mentioned on the lowest used line of part I. Therefore, in the example above, “Chronic hepatitis C” infection will be selected as the underlying cause of death for the purpose of producing statistics.

This is particularly important if a death was caused *by a mixture of natural and other causes*. For example, a death due to “chronic drug misuse and atherosclerotic cardiovascular disease” *will be counted in the statistics as drug-related*, whereas if the cause was given as “atherosclerotic cardiovascular disease and chronic drug misuse”, *it will be counted as due to natural cause*. Therefore, if you are unsure which condition caused the death, but have a slight suspicion as to what the main one was, put it at the start of the line.

NRS codes all conditions mentioned on the certificate. Multiple causes of death data are used in a variety of ad hoc analyses, and can be made available for research in some circumstances. Multiple cause data provide useful additional information on the mortality burden associated with diseases that are not often selected as the main cause of death. For example, conditions that are very often complications of another disease or its treatment, *such as deep vein thrombosis/pulmonary embolism or healthcare associated infections* should rarely be the underlying cause of death. Their contribution to mortality is better estimated from multiple cause data. You must tick the box “PM1” if information from a post mortem examination is included in the MCCD.

In contrast to the above, **if you do not know that your patient actually had any specific disease compatible with the mode and circumstances of death**, you must consider whether the death requires to be reported to the PF, in accordance with the [PF guidance](#)²¹. For example, if your patient, who was young and who did not have any relevant clinical history, and to the best of your knowledge and belief you cannot accurately complete the MCCD, then it may be that in such circumstances, and in the absence of a hospital post mortem examination, the death will require to be reported to the PF. However, if your patient died after a sudden onset of chest pain that lasted several hours and although you have no way of knowing definitively whether he or she may have had a myocardial infarct, a pulmonary embolus, a thoracic aortic dissection, or another pathology, which caused the chest pain, it would be reasonable to provide a cause of death, based on your clinical judgement in the context of the previous clinical history and on the balance of probabilities. You may wish also to discuss the circumstances of the death with the PF and other colleagues/educational supervisor/specialist in charge of the case. Certainty is not required. Relating to the cause of death, words such as “probable” and “presumed” are permissible in an MCCD. . Authorisation from the patient before their death or from the next of kin/legal guardian/executor of the deceased’s estate is required for hospital post mortem autopsies.

²¹<http://www.copfs.gov.uk/images/Documents/Deaths/Reporting%20Deaths%20to%20the%20Procurator%20Fiscal%202014.pdf>

5.3 Results of investigations awaited

If in broad terms, you know the disease that caused your patient's death, but you are awaiting the results of laboratory investigation for further detail, you need not delay completing the MCCD. For example, a death can be certified as bacterial meningitis once the diagnosis is firmly established, even though the organism may not yet have been identified. However, any other procedures required should be undertaken, such as, notification to the Health Board under the [Public Health etc \(Scotland\) Act 2008](#), and to the PF (if the risk to others is significant). Similarly, a death from cancer can be certified as such while still awaiting detailed histopathology. This allows the family to register the death and arrange the funeral. However, you should indicate clearly on the MCCD that information from investigations might be available later. You can do this by ticking "PM2" on the MCCD for post-mortem (autopsy) information, or by ticking the "extra information for statistical purposes" "box X" on the certificate for results of investigations e.g. toxicology, histology or microbiology, initiated ante-mortem. It is important for public health surveillance to have this information on a national basis, for example, to know how many meningitis and septicaemia deaths are due to meningococcus, or to other bacterial infections. NRS will write to the certifying doctor whether a General Practitioner (GP), or for hospital deaths, the Consultant in charge of the patient's care, sometime after death, requesting further details of any other information which might help to make the cause of death clearer. **NRS will use such information for statistical purposes. The MCCD or the Form 14 will not normally be changed based on further information gained from these enquiries.**

Section 9 describes what you should do if you wish to change the public record of the cause of death.

It is important that you respond fully to any request from NRS for additional information to enable the death to be counted correctly in statistics, which are used to develop public health policies. Health practitioners and researchers need such statistics based on complete and accurate information about the cause of death in order to understand the scale of various health problems and develop effective interventions to improve the health of the population.

If a certificate is issued prior to completion of e. g. histological or toxicological cases, such as in deaths due to misuse of substances, the wording "unascertained pending test results" may

be used in line I(a) by Forensic Pathologists. Forensic Pathologists and the doctor/s who were involved in the management of the deceased prior to death will be asked by NRS to provide more details later. Please do so even if the death has been or is being investigated by the PF.

5.4 Use of “old age” alone

“Old age” or “frailty due to old age” should only be given as the **sole** cause of death when all of the following criteria have been met.

These are:

- The patient is 80 years or older **and** all the condition listed below are met
- You have personally or your clinical team have cared for the deceased over a long period (years, or many months)
- You have observed a gradual decline in your patient's general health and functioning
- You are not aware of any identifiable disease or injury that contributed to the death
- You are certain that there is no other reason that the death should be reported to the PF

You should bear in mind that the PFs, NRS, and organisations that regulate standards in health and social care, may ask you to support your statement with information from the relevant medical records of the deceased and any investigations that might have a bearing on the cause of death.

You should also be aware that the deceased’s family may not regard “old age” as an adequate explanation for their relative’s death and may request an “Interested Person” review by the MR, which will be a Level 2 review, or further investigation by the appropriate authorities.

It is unlikely that patients would be admitted to an acute hospital if they had no apparent disease or injury. It follows, therefore, that deaths in acute hospitals are unlikely to fulfil the conditions above. You can specify old age as the underlying cause of death, but you should also mention in part I or part II, as appropriate, any medical or surgical conditions that may have contributed to the death.

Example A:

Ia. Pathological fractures of femoral neck and thoracic vertebrae

Ib. Severe osteoporosis

Ic. Old age

II. Interstitial lung disease

Example B:

Ia. Old age

II. Type 2 diabetes mellitus (mild age related), essential hypertension and diverticular disease

Example C:

Ia. Hypostatic pneumonia

Ib. Vascular dementia

II. Old age

5.5 Never use “natural causes” alone

The term “natural causes” alone, with no specification of any disease on an MCCD, is not sufficient to allow the death to be registered. If you do not have the necessary information to state to the best of your knowledge and belief what disease caused your patient’s death, then in the absence of a post mortem examination, it is unlikely that you can accurately complete the MCCD. It may be that, in such circumstances, the death will require to be reported to the PF to ensure that the circumstances of the death are investigated. The PF is not medically trained, does not adjudicate on what causes of death are medically acceptable, and does not certify deaths. Therefore, all efforts must be made to provide a cause of death to best of your knowledge and belief, on the balance of probabilities, with or without a discussion with the PF and other colleagues/educational supervisor/specialist in charge of the case, as certainty is not required. Use words such as “probably” or “presumably” if uncertain.

As explained in Section 3, since the implementation of the Certification of Death (Scotland) Act 2011, MRs from the DCRS can be a source of advice.

5.6 Avoid organ failure alone

Do not certify deaths as due to the failure of any organ or “multiple organ failure”, without specifying the disease or condition that led to the organ failure. If you suspect that, the organ failure may have been due to unnatural causes, such as accidental or deliberate poisoning, injury or industrial disease; or other circumstances, which may require the death to be reported to the PF, then these, should be reported to the PF.

Example A:

Ia. Renal failure

Ib. Necrotising proliferative nephropathy

Ic. Systemic lupus erythematosus

II. Raynaud's phenomenon and vasculitis

Example B:

Ia. Liver failure

Ib. Hepatocellular carcinoma

Ic. Chronic hepatitis B infection

Example C:

Ia. Congestive cardiac failure

Ib. Essential hypertension

Conditions such as renal failure may come to medical attention for the first time in frail and elderly patients, in whom vigorous investigation and treatment may be contraindicated, even though the cause is not known. When such a patient dies, you can complete the MCCD to the best of your knowledge and belief, on the balance of probabilities, with the information that you have or have sought from others. It may be that, in such circumstances, you may also wish to discuss the circumstances of the death with your colleagues/educational supervisor/specialist in charge of the case and the PF. Use words such as “probably” or “presumably” if uncertain.

5.7 Avoid terminal events, modes of dying and other vague terms

Terms that do not identify a disease or pathological process clearly are not acceptable as the only cause of death. This includes terminal events, or modes of dying such as cardiac or respiratory arrest, syncope or shock. Very vague statements such as cardiovascular event or incident. Debility or frailty are equally unacceptable if used alone and without more information about a condition such as Alzheimer's dementia or old age. "Cardiovascular event" could be intended to mean a stroke or myocardial infarction. In addition, it could include cardiac arrest or fainting, or a surgical or radiological procedure. Every effort must be made to provide a cause of death on the balance of probabilities, with or without a discussion with the PF, and other colleagues/educational supervisor/specialist in charge of the case, as certainty is not required.

5.8 Never use abbreviations or symbols

Do not use abbreviations on MCCDs. Their meaning may seem obvious to you in the context of your patient and their medical history, but it may not be clear to others and therefore may be a source of ambiguity, cause of potential delay to the registration process and some cases, may even cause offence. For example, does a death from "MI" refer to myocardial infarction or mitral incompetence? Is "RTI" a respiratory or reproductive tract infection, or a road traffic incident? The registrar **cannot accept a certificate that includes abbreviations.** (The only exceptions, which the registrar can accept, are HIV and AIDS for human immunodeficiency virus infection and acquired immune deficiency syndrome). You, or the GP, or the Consultant/Specialist in charge of the care of the deceased, as appropriate, may be required to complete a new certificate with the conditions written out in full, before the death can be registered. This is inconvenient for you and for the family of the deceased. **The same applies to medical symbols such as Rx, Tx, Dx, +ve, #, ?, TMN classification for cancers, etc. Use words such as "probably" or "presumably" if uncertain. Please write legibly if providing a hand written MCCD.**

5.9 Neonatal deaths

It is important to parents to state the name of the infant on the MCCD, and you must make all reasonable efforts to include a name acceptable to the parents. Some parents may not name their children immediately and may agree an alternative.

CHI numbers will not be provided specifically for registration of deaths e.g. a 23 week pregnant woman delivers early and the baby unfortunately survives for a very short time and

it is a “neonatal death” e.g. a few minutes or a few hours. The registrar will accept the MCCD in this case without the CHI number.

All neonatal deaths must be registered.

Neonatal deaths are manually scrutinised by the coders in NRS. Maternal codes are not used for the neonates and if the software used applies a maternal ICD code, this will be manually changed by NRS. However, it is important to record the relevant maternal conditions on the MCCD, although these will not be coded as the underlying cause of death. The maternal information is useful as it can be used in a variety of analyses and for research. It is important to note that while other countries may use a separate and different MCCD for perinatal deaths, this is not the case in Scotland.

If a baby dies after withdrawal of life sustaining treatment, the cause of death is the underlying condition that led to the death and the antecedent factors. Withdrawal of treatment itself is not the cause of death.

Extremely premature babies usually die of a condition, which led to extreme prematurity, even where active treatment is not provided. Respiratory Distress Syndrome or pulmonary hypoplasia is a consequence of extreme prematurity. Survival of a baby is currently rare before 22 weeks gestation.

Example:

1a. Pulmonary hypoplasia

1b. Extreme prematurity

1c. Fetus affected by premature rupture of membranes

6. **SPECIFIC CAUSES OF DEATH**

6.1 Stroke and cerebrovascular disorders

Give as much detail about the nature and site of the lesion as is available to you. For example, specify whether the cause was haemorrhage, thrombosis or embolism, and the specific artery involved, if known. Remember to include any antecedent conditions or treatments, such as atrial fibrillation, artificial heart valves, or anticoagulants that may have led to cerebral emboli or haemorrhage.

If the term “cerebrovascular accident” is used the death cannot be registered. The registrar will require an email amendment to the MCCD. If no more specific description is available, use terms such as “ischaemic stroke” or “cerebral infarction”, if no more specific description can be given.

Example A:

Ia. Subarachnoid haemorrhage

Ib. Ruptured aneurysm of anterior communicating artery

Example B:

Ia. Intraventricular haemorrhage

Ib. Warfarin anticoagulation

Ic. Atrial fibrillation

6.2 Neoplasms

Malignant neoplasms (cancers) remain a major cause of death. Accurate statistics are important for planning care and assessing the effects of changes in policy or practice. You should indicate whether a neoplasm was benign, malignant, or of uncertain behaviour. Please remember to specify the histological type and anatomical site of the primary cancer, if known.

Example:

Ia. Carcinomatosis

Ib. Small cell carcinoma of left main bronchus

Ic. Heavy smoker

II. Hypertension, cerebral arteriosclerosis, ischaemic heart disease.

You should make sure that there is no ambiguity about the primary site if both primary and secondary cancer sites are mentioned. Do not use the terms “metastatic” or “metastases” unless you specify whether you mean metastasis to, or metastasis from, the named site. For example, "Metastatic lung cancer" could mean metastases to the lung from another primary or from the lung to elsewhere in the body. This would be better described as "Metastases to the lung" or “Metastases from lung cancer”

Example B:

- Ia. Intraoperative haemorrhage*
- Ib. Ruptured metastatic deposit in liver*
- Ic. Metastases to liver*
- Id. Primary adenocarcinoma of ascending colon*

II. Type 2 diabetes mellitus (Mild obesity related)

Example C:

- Ia. Pathological fractures of left shoulder, spine and shaft of right femur*
- Ib. Widespread skeletal secondaries*
- Ic. Primary adenocarcinoma of breast*

II. Hypercalcaemia

Example D:

- Ia. Lung metastases*
- Ib. Testicular teratoma*

If you mention two sites that are independent primary malignant neoplasms, make that clear.

Example E:

- Ia. Massive haemoptysis*
- Ib. Primary small cell carcinoma of left main bronchus*

II. Primary adenocarcinoma of prostate

If a patient has widespread metastases, but the primary site could not be determined, you should state this clearly

Example:

- Ia. Multiple organ failure*
- Ib. Poorly differentiated metastases throughout abdominal cavity*
- Ic. Unknown primary site*

If you do not yet know the cancer type and are expecting the result of histopathology, indicate that this information may be available later by ticking the “extra information for statistical purposes box X” on the certificate for results of investigations initiated ante-mortem.

You, or the GP, or the Consultant in charge for the deceased’s care, as appropriate, will be sent a letter requesting this information later.

If the histology is unknown e.g. if the patient was too unfit to have the biopsy taken or refused investigation, then this does not need to be stated explicitly or an explanation given. If it is not possible to be more specific than e.g. “tumour” or “mass”, then use a qualifier such as “probable” or “suspected” to indicate that no further information is known. Prognosis and staging information should not be included e.g. TNM or Gleason score.

In the case of leukaemia, specify whether it is acute or chronic, and the cell type involved.

Example G:

Ia. Neutropenic sepsis

Ib. Acute myeloid leukaemia

Example H:

Ia. Haemorrhagic gastritis

Ib. Chronic lymphatic leukaemia

II. Myocardial ischaemia, valvular heart disease

6.3 Diabetes Mellitus

There is an increasing evidence base around the complexity of accurately diagnosing diabetes subtypes and the WHO classification of diabetes is being used in Scotland to record the type of diabetes as accurately as possible within SCI-diabetes.

Always remember to specify the type of diabetes, such as whether your patient’s diabetes was:

- Type 1, diabetes (due to β -cell destruction, usually leading to absolute insulin deficiency. This includes classical, idiopathic and Latent Autoimmune Diabetes of Adults, – LADA)
- Type 2 diabetes (due to a progressive insulin secretory defect on the background of insulin resistance)

- Gestational Diabetes Mellitus (GDM - diabetes diagnosed in the second or third trimester of pregnancy that is not clearly overt diabetes)
- Other: specific types of diabetes due to other causes, e.g., monogenic diabetes syndromes (such as neonatal diabetes and maturity-onset diabetes of the young [MODY]), diseases of the exocrine pancreas (such as cystic fibrosis), and drug- or chemical-induced diabetes (such as in the treatment of HIV/AIDS or after organ transplantation)

Additional information about the type of diabetes will be helpful, since sometimes there might be a more general description (for example specifying a particular genetic syndrome with diabetes) rather than simply a type.

If diabetes is the underlying cause of death, specify any complication or consequence that led to death, such as ketoacidosis.

Example:

Ia. End-stage renal failure

Ib. Diabetic nephropathy

Ic. Type 1 diabetes mellitus (LADA)

Example:

Ia. Septicaemia – Non-resistant Staphylococcus aureus

Ib. Gangrene of both feet due to peripheral vascular disease

Ic. Type 2 diabetes mellitus

II. Ischaemic heart disease

6.4 Dementia

Increasingly, dementia is being recorded as the cause of death. It is sometimes not obvious that dementia, whether specified or unspecified, is the underlying cause of death or a significant contributing factor in the death.

Give as much detail about the type of dementia e.g. alcohol related, Alzheimer's disease, vascular, etc., and nature and site of the lesion. For example, specify whether the cause was

haemorrhage, thrombosis or embolism, and the specific artery involved, if known. If this is not known, or not clear, then Mixed dementia or unspecified dementia should be used. Remember to include any antecedent conditions or treatments, such as atrial fibrillation, artificial heart valves, or anticoagulants that may have led to cerebral emboli or haemorrhage.

Example A:

Ia. Community Acquired pneumonia.

Ib. Alzheimer's disease

II. Chronic obstructive pulmonary disease

Example B:

Ia. Increasing general debility

Ib. Mixed dementia (Alzheimer's and vascular)

Example C:

Ia. Reduced oral intake

Ib. Dementia (unspecified)

Example D

Ia. Aspiration pneumonia

II. Alzheimer's disease

6.5 Deaths involving infections and communicable diseases

Mortality data is important in the surveillance of infectious diseases, as well as monitoring the effectiveness of immunisation and other prevention programmes. If you have a reasonable suspicion that the deceased person had a notifiable disease, either as a cause of death or not, you have a statutory duty to notify the local Health Board (in practice the local Health Protection Team within the Public Health Department), unless the case has already been notified. If you are in any doubt about whether a case is notifiable, you should contact

your local Health Protection Team for advice. The list of notifiable diseases is contained in [Schedule 1, part 1 of the Public Health etc. \(Scotland\) Act 2008](#)²².

The Health Protection Team will also wish to ensure that those handling the body know the nature of any risk to public health and any precautions, which should be taken, as this is a statutory duty placed on the Health Board.

The [GMC Guidance on Confidentiality](#)²³ (most recent edition of September 2017) makes it clear that if a serious communicable disease has contributed to the cause of death, doctors must record this on the MCCD. The guidance for doctors on [Good Medical Practice](#)²⁴ (paragraph 71) reminds doctors of their duty to be honest and trustworthy when completing or signing forms and their legal duty to complete MCCDs honestly and fully including for serious communicable diseases. This includes the condition leading to or contributing to the death. Decisions have to be made on a case by case basis. It may be helpful to speak to a senior colleague, or a representative organisation such as the Medical Defence Organisation. Sometimes discussing the issues related to the cause of death with the family/next of kin, if appropriate, may be helpful.

Further information is available in section 7.6 – Hazards.

In deaths from infectious disease, you should state the manifestation or body site, e.g. pneumonia, pyelonephritis, hepatitis, meningitis, septicaemia, or wound infection. You should also specify if known:

- The infecting organism, e.g. *pneumococcus*, *influenza A virus*, *meningococcus*
- Antibiotic resistance, if relevant, e.g. *meticillin resistant Staphylococcus aureus*, or *multiple drug resistant Mycobacterium tuberculosis*
- The source and/or route of infection, if known, e.g. *food poisoning*, *needle sharing*, *contaminated blood products*, *post-operative*, *community or hospital acquired*, or *health care associated infection*.

Avoid using abbreviations or acronyms such as MRSA or E.Coli.

²² http://www.legislation.gov.uk/asp/2008/5/pdfs/asp_20080005_en.pdf

²³ https://www.gmc-uk.org/-/media/documents/confidentiality-good-practice-in-handling-patient-information---english-0417_pdf-70080105.pdf

²⁴ https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf

Example:

Ia. Bilateral pneumothoraces

Ib. Multiple bronchopulmonary fistulae

Ic. Extensive pulmonary tuberculosis

II. Iron deficiency anaemia; ventilator associated pseudomonas aeruginosa pneumonia

You need not delay completing the certificate until laboratory results are available, provided you are satisfied that the death is not one in which the circumstances require to be reported to the PF. You should indicate, by ticking “extra information available for statistical purposes box X” on the certificate for results of investigations initiated ante-mortem, that further information may be available later. A letter will then be sent to you, or the GP, or to the Consultant in charge of the care of the deceased, as appropriate, requesting this information. The coded cause of death will be amended for statistical purposes.

Remember to specify any underlying disease that may have suppressed the patient's immunity or made them more susceptible to the infection that led to the death. It is also useful to specify any appliances or implants, which may have contributed e. g. an indwelling urinary catheter.

6.5.1 Healthcare Associated Infections (HAI)

It is a matter for your clinical judgment, whether a condition the patient had contributed to their death, and therefore, should be included on the MCCD. While families may be surprised if you do not include something that they believe contributed to their relative's death, it is your clinical judgment that must be recorded.

Where infection does follow treatment, including surgery, radiotherapy, antineoplastic, immunosuppressive, antibiotic or other drug treatment for another disease, remember to specify the treatment and the disease for which it was given.

If a Healthcare Associated Infection (HAI) was part of the sequence leading directly to death, it should be in part I of the certificate, and you should include all the conditions in the sequence of events back to the original disease being treated.

It is important to emphasise that it is only HAI deaths, which pose an acute and serious public health risk, which must be reported to the PF, as described in the [PF guidance](#)²⁵. If you are unsure, you can contact your Public Health Department for advice. Alternatively, you could contact the PF for advice. However, telephoning for advice does not mean that you have reported a death to the PF. If the PF decides that the death should be reported, you will have to complete the necessary forms to report the death to the PF.

Reporting of an HAI related death will not necessarily lead to further investigation of the cause of death by the PF. It may be that, following discussion with you, the PF will be content with the terms of the MCCD that you propose. Identification and investigation of any clusters of HAI related deaths that may imply an acute and serious public health risk will be through the monitoring undertaken by Health Boards, supported by Health Protection Scotland (HPS), NRS and Information Services Division (ISD) of NHS National Services Scotland.

Example A:

- 1a. Clostridium difficile pseudomembranous colitis*
- 1b. Multiple antibiotic therapy*
- 1c. Community acquired pneumonia with severe sepsis*

II Immobility, Polymyalgia Rheumatica, Osteoporosis

Example B:

- 1a. Bronchopneumonia (hospital acquired meticillin resistant Staphylococcus aureus)*
- 1b. Multiple myeloma*

II Chronic obstructive airways disease

If your patient had an HAI which was not part of the direct sequence of events leading to death, but which you think contributed to their death, it should be mentioned in part II.

Example C:

- 1a. Carcinomatosis and renal failure*
- 1b. Adenocarcinoma of the prostate*

²⁵<http://www.copfs.gov.uk/publications/deaths>

II. Chronic obstructive airways disease, catheter associated Escherichia coli urinary tract infection

6.5.2 Pneumonia

Pneumonia may present in previously fit adults, but often it occurs as a complication of another disease, such as those affecting the lungs, mobility, immunity, or swallowing. Pneumonia may also follow other infections and may be associated with treatment for disease, injury or poisoning, especially when ventilatory assistance is required. Remember to specify, where possible, whether it was lobar or bronchopneumonia and whether primarily hypostatic, or related to aspiration and the organism involved. You should include the whole sequence of conditions and events leading up to it. If known, specify whether the pneumonia was hospital or community acquired. If it was associated with mechanical ventilation, or invasive treatment, this should be clearly stated.

Example A:

Ia. Lobar pneumococcal pneumonia

Ib. Influenza A

II. Ischaemic heart disease

For many years, bronchopneumonia was given as the immediate cause of death on a large proportion of certificates. This may have reflected common terminal chest signs and symptoms, rather than significant infection in many cases. Since 2003 deaths where the underlying cause was assigned to unspecified bronchopneumonia has fallen. If you do report bronchopneumonia, remember to include, in the sequence in part I, any predisposing conditions, especially those that may have led to it, e. g. paralysis, immobility, depressed immunity or wasting, as well as chronic respiratory conditions such as chronic bronchitis.

Example:

Ia. Bronchopneumonia

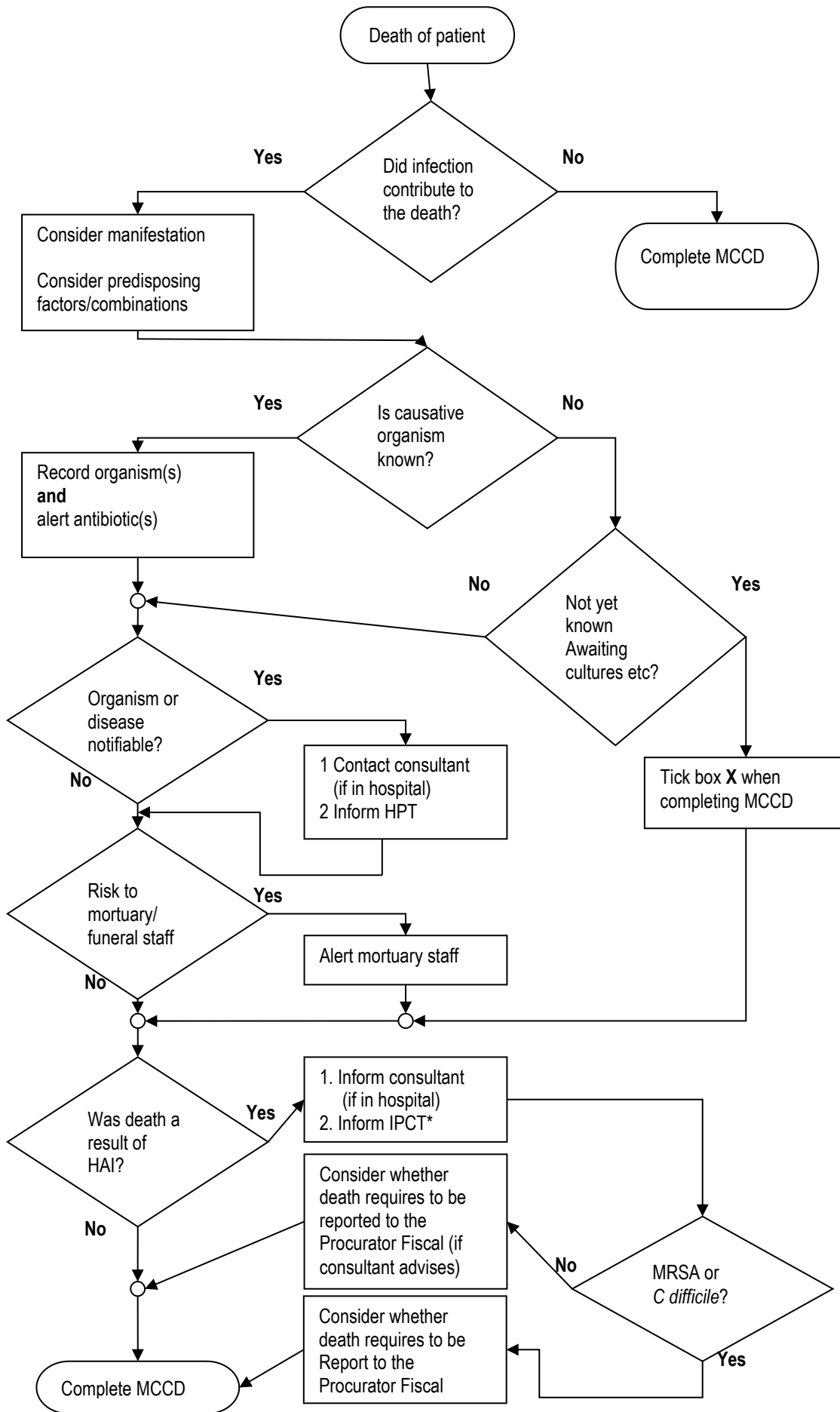
Ib. Immobility and wasting

Ic Alzheimer's disease

“Sarcopenia” will be accepted by NRS. However, as this term is not indexed in ICD 10, it would be coded as “wasting”, which is indexed in ICD 10.

6.5.3 Healthcare Associated Infection (HAI) flow chart

The definition of what constitutes a HAI can be difficult. HAI includes meticillin resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile infections, but it can include other infections. The flow chart for hospital staff below may help and you can obtain further information from the Health Protection Teams (HPT), or Infection Prevention and Control Teams (ICPT) in the case of HAI, in your Health Boards, including Infection Control Doctors (ICD).



6.6 Injuries and external causes

Any death where there is evidence or suspicion of homicide or suicide must be reported to the PF in accordance with the [PF guidance](#)²⁶. You should contact the Police as soon as possible, as they will take responsibility for reporting the death to the PF. For example, a certifying doctor who is of the view that external injuries on a deceased, a high impact fall, or poisoning of the deceased has contributed to the death, should report the death to the Police.

The mere fact that has deceased has injuries does not necessarily mean that the death must be reported to the PF. For example, if the deceased patient has a cut on their left leg, but otherwise presented with a cardiac problem and relevant history, and subsequently died of cardiac failure, then the presence of the external leg injury would not of itself require the death to be reported to the PF.

Full details of how the injury occurred should be recorded in the deceased patient's clinical records. This should include the place where it is said to have happened, such as home (address specified), in the street (street name), or at work (work address). A full note of any discussions with the PF should be recorded in the deceased's clinical records.

Example:

Ia. Pulmonary embolism

Ib. Hemiarthroplasty

Ic. Fractured neck of femur

Id. Tripped on loose floor rug at home

II. Left sided weakness and difficulty with balance since haemorrhagic stroke

Remember to state clearly if a fracture was pathological, i.e. due to an underlying disease process such as a metastasis from a malignant neoplasm or osteoporosis.

When causes of death such as self-neglect or self-injury are due to psychiatric illness, the psychiatric illness should be mentioned as a contributory factor or underlying cause of death as appropriate.

²⁶<http://www.copfs.gov.uk/publications/deaths>

6.7 Substance misuse

Deaths from diseases related to chronic alcohol or tobacco use of themselves do not need to be reported to the PF, provided the disease is clearly stated on the MCCD. It is important to mention issues of importance to monitor public health, such as alcohol misuse or tobacco intake (in any form e.g. cigarettes, chewing, etc.) and obesity. All of these entries require the duration to be given. If smoking contributed to death but the deceased had stopped smoking some time before death then this can be described as "Previous smoker" and give the interval from when they first smoked.

Example:

Ia. Carcinomatosis

Ib. Bronchogenic carcinoma upper lobe left lung

Ic. Heavy smoker

II. Chronic bronchitis and ischaemic heart disease.

Example:

Ia Hepatic encephalopathy

Ib Alcoholic liver cirrhosis

II Poorly controlled Type 2 diabetes mellitus

Deaths which are due to **acute or chronic poisoning, by any substance, and drug related deaths involving dependence or misuse of substances other than alcohol and tobacco** should be reported to the PF, as these types of deaths have the potential to be suicides or criminal/homicidal in nature. The Police should be contacted as soon as possible, who will take responsibility for reporting the death to the PF.

6.8 Mesothelioma

[Mesothelioma caused by occupational exposure to asbestos is a well-recognised condition and sufferers can claim compensation \(Industrial Injuries Disablement Benefit\)²⁷](#). Stringent

²⁷ [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)07.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)07.pdf)

criteria must be fulfilled in order to establish the link between occupational exposure and mesothelioma and to this end the Procurator Fiscal (PF) is notified after the patient's death, both to elucidate the individual situation and "for the common good".

There is no need to report to the PF if compensation has already been paid.

In a patient with known asbestos exposure, a "diagnostic hierarchy" exists:

- The diagnosis may be suspected from the clinical history.
- It is usually endorsed by radiological investigations.
- It is generally (but not always) confirmed by cytology or histology.
 - o Sometimes pleural fluid analysis may suffice to establish the diagnosis.
 - o A more invasive video assisted thoracoscopic surgical (VATS) biopsy would provide a more robust diagnosis, but may be deferred if the patient is frail. In such circumstances, a diagnosis of "probable mesothelioma" may be made if there is a history of asbestos exposure, a typical clinical course and radiological evidence of pleural involvement.
- Evidence of Multi-Disciplinary Team (MDT) discussion, providing a consensus opinion, lends considerable weight to the balance of probabilities of the likely diagnosis of mesothelioma.
- The provision of treatment according to guidelines for mesothelioma would be further confirmation of the diagnosis.

[A pro forma](#)²⁸ (see **Annex 3**) has been devised to reduce distress caused to relatives when a patient with mesothelioma dies. It distils the information required by the Procurator Fiscal (detailed above) and obviates the need for relatives to be interviewed at a very stressful time for them. Once the death has been verified, the deceased can be respectfully removed by the funeral director, with the instruction not to undertake any preparations of the body for the funeral until agreed by the PF. When you report the death to the PF, you also need to provide the pro forma to the PF. The PF will return Form 3 with the decision regarding post mortem to the notifying doctor. This should be filed in the medical record (paper or electronic) of the deceased with parts 1 and 2.

If adequate information is available ante mortem and compensation has been obtained, a post mortem is not required.

²⁸<http://www.sad.scot.nhs.uk/media/15671/cmo-pfs-mesothelioma-pro-forma-final-version-v2-18-march-2014.pdf>

If compensation has not been obtained a post mortem is not required if a form (see Appendix) has been received from the patient's solicitor, confirming that adequate histology has been recovered.

If histology is unavailable or inconclusive a post mortem will be necessary, but a limited post mortem may suffice.

Of the "Other Asbestos Related Diseases", currently compensation is available only for Asbestos related Lung Cancer.

6.9 Benefits System as a contributory factor

You would probably not be best placed to have the required information to link the condition, which resulted in the death due to the lack of adequate finances, which in turn was due to inadequate benefit. If you had such information, you would then be able to say, to the best of your knowledge and belief in a legal document, whether the benefits system was a contributory factor. Other professionals would probably have better information about the financial circumstances of individuals, such as social workers.

For example, the relevant ICD 10 code, which could be used by NRS, would be: Z55 – Z66 – Persons with potential health hazards related to socioeconomic and psychosocial circumstances.

7. OTHER AREAS IN the MCCD (FORM 11 or F(11))

PART A – DETAILS OF THE DECEASED

7.1 Date and time of death

You should record the date and time of death as accurately as possible. This may be required for legal or religious reasons. If a person such as a nurse, relative or a carer was present when the person died, you may record reliable information that they give you about the date and time of death. Otherwise, please give your best estimate based on all the information available to you. **Do not use the time of your attendance or when you pronounce life extinct (or when death was verified or confirmed i.e. the date and time you or the healthcare professional completed the absence of clinical signs tests),**

unless you or a [registered healthcare professional](#)²⁹ were present at the time of death.

Please only enter one time and date of death. In exceptional circumstances, a range in which death is likely to have occurred may be provided in the free text box by Forensic Pathologists e.g. around one year, or 3 to 4 weeks.

You must ensure that the correct date of death is recorded in the MCCD when you certify a death, which occurred before midnight, but you complete the certificate the following day.

7.2 Place of death

You should record, to the best of your knowledge, exactly where the person died (for example hospital, care home, private house, own home, etc., along with the relevant address, including postcode). If the person did not die in a place that can be readily identified by an address and description as above, give the location (for example, a particular stretch of motorway or a specific area of countryside), avoiding abbreviations which can be misinterpreted.

7.3 CHI (Community Health Index) number

You should record the CHI number in the MCCD, or in the documents when reporting a death to the PF. Most patients residing in Scotland will have a CHI number. This is a 10-digit number commencing with 6 digits of the date of birth followed by further 4 digits, which distinguish, between people with the same date of birth – it is the entire 10 digits, which make up the CHI number.

Registrars are aware that the CHI number may not be available in some infrequent and specific circumstances such as stillbirths; people not resident in Scotland (e.g. holidaymakers from overseas or other parts of the United Kingdom, and other temporary residents); and infants, including those less than 24 weeks gestation, who live only for a short time after birth.

²⁹ [http://www.sehd.scot.nhs.uk/dl/DL\(2017\)09.pdf](http://www.sehd.scot.nhs.uk/dl/DL(2017)09.pdf)

It is important that CHI numbers are **not** created solely for the purposes of death registration as the creation of a CHI record may lead to other health service actions and has potential risks (e.g. deceased patients may be called for NHS screening programmes).

7.4 Maternal death (M1 and M2)

You should consider if the deceased could have been pregnant within the year before she died and tick box M1 or M2 as appropriate, regardless of the cause of death. This is to ensure that there is complete recording of maternal deaths nationally, and that pregnancy is always considered as a possible cause of death.

7.5 Signature of doctor and Specialist's name (PART B)

You must sign the certificate, include your GMC reference number (also known as the GMC registration number), and add the date. You should also **print your name clearly in BLOCK CAPITAL LETTERS**. You may use a stamp with your business address if available and if it is practical to use. You should not use your domestic or personal address or telephone number/s, but record the address of the place of your work, (such as a hospital or General Practice), and business telephone number. You must give a business telephone number, which is also available through your place of work (e.g. via the hospital switchboard). If the patient died in hospital, you should also include the ward or the department where the patient died, and the Specialist in charge of the patient.

You must not sign an MCCD with another doctor's details on their behalf. Instead, if required, you should re-issue an MCCD with your own details.

7.6 Hazards (PART D – DH1, DH2, DH3)

While reporting information related to “hazards”, some of the principles that you should consider are that:

- The extract from the register of deaths or the Certificate of the Registration of Death (Form 14) is a publically-available document. It includes your description of the cause of death and the information about “hazards” (Parts C and D of the MCCD in Annex 1). The MCCD itself (Form 11) is **not** publically-available, as it is covered by patient confidentiality and is destroyed by the registrars after 3 years retention by them.

- The Data Protection Act does not apply to people who are deceased, but information disclosure is governed by the [Access to Health Records Act 1990](#)³⁰ e.g. the duty of confidentiality remains after a patient has died and the personal representative of the deceased and people who may have a claim arising from the patient's death are permitted access to the records. In addition, GMC provides guidance on disclosure of the records of the deceased (paragraphs 70-72 [GMC Guidance on Confidentiality](#)³¹) e.g. GMC advises that doctors have a duty of confidentiality to patients who are deceased. However, the duty of confidentiality is not absolute. Personal information can be disclosed in certain circumstances such as if it is "required by law; the patient consents – either implicitly for the sake of their own care or expressly for other purposes; and/or it is justified in the public interest" (paragraph 8 of the [GMC Guidance on Confidentiality](#)³²). Consent can only be given on behalf of the deceased by the next of kin/legal guardian/executor of the deceased's estate. [NHSScotland Guidance on Patient Confidentiality](#)³³ also provides guidance to healthcare professionals working in NHSScotland.
- The funeral directors and others have a duty of care to their staff and their customers (e.g. those who physically come into contact with the body). It is a criminal offence (which carries a custodial sentence) under the Health and Safety legislation if someone becomes infected or injured through failure of appropriate action by relevant people. The National Association of Funeral Directors (NAFD) is of the opinion that, in the event of an accidental contamination, a funeral director being told verbally of the presence or absence of a particular risk by the family or the mortuary staff at the hospital, is highly unlikely to be viewed as sufficient or robust evidence of the presence or absence of a hazard as defined by the Health and Safety Executive (HSE). Further information is available from the [HSE guidance](#)³⁴.
- Regarding Notifiable diseases, [Guidance on Part 2 - Notifiable Diseases, Notifiable Organisms and Health Risk States](#)³⁵ of The Public Health etc. (Scotland) Act 2008 lists the diseases, organisms and health risk states which are to be notified by a medical practitioner to the Health Board, and can be accessed through the guidance attached link below. A health risk state is categorised as infectious, a result of contamination (e.g. with radioactive material), or the result of a toxin or poison to which others may be

³⁰ <http://www.legislation.gov.uk/ukpga/1990/23/section/3>

³¹ https://www.gmc-uk.org/Confidentiality_0513_Revised.pdf_52090934.pdf

³² https://www.gmc-uk.org/Confidentiality_0513_Revised.pdf_52090934.pdf

³³ <http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4011563/Revised%20Code%20of%20Confidentiality%20-%20Final.pdf>

³⁴ <http://www.hse.gov.uk/pUbns/priced/hsg283.pdf>

³⁵ <http://www.scotland.gov.uk/Topics/Health/Policy/Public-Health-Act/Implementation/Guidance/Guidance-Part2>

exposed. Please note the advice in the guidance that if you have any doubts about whether to notify a condition, on the grounds of its seriousness or potential to affect others, you should discuss the condition with the local Health Protection Team or another senior colleague. The Notifiable diseases and organisms include several blood borne viruses.

You are required to tick the relevant sections in boxes DH1, DH2 and DH3 on the MCCD confirming the presence or absence of any potentially hazardous implants to the best of your knowledge and belief. You should not provide the details of the hazards on the MCCD.

As incomplete or incorrect recording of hazards constitutes a “major error” in the completion of the MCCD, it will require the MCCD to be re-issued. This will cause additional work for you, as well as causing a delay in the funeral arrangements.

Based on guidance and legislation as explained in the principles above, when disclosing detailed information of the hazard to relevant person/s, you will need to make decisions on a case by case basis, taking account of the context, the views of others where appropriate, and using your clinical judgement.

The funeral directors and burial and cremation authorities will have access to Form 14 which will contain the information from Part D of the Form 11 regarding hazards.

The body may pose a risk to people who come into close contact with it, such as embalmers, or next of kin who lay out the body for the funeral, or others (e.g. risks can include an air borne communicable disease, such as Pulmonary TB; blood borne such as hepatitis C; the result of exposure and presence of radioactive material; and the result of a toxin or poison to which others may be exposed).

It is also important to confirm whether the deceased person has had an implant fitted in life as some implants may cause damage to the cremator, and may even be a serious health and safety risk to the people in the vicinity of the cremator, (e.g. if they explode during the process of cremation). A current list (this may change in the future), of potentially dangerous implants is included below:

Battery powered and other implants that could cause problems during cremation include:

- Pacemakers

- Implantable Cardioverter Defibrillators (ICDs)
- Cardiac resynchronization therapy devices (CRTDs)
- Implantable loop recorders
- Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs)
- Implantable drug pumps including intrathecal pumps
- Neurostimulators (including for pain & Functional Electrical Stimulation)
- Bone growth stimulators
- Hydrocephalus programmable shunts
- Any other battery powered implant
- Fixion nails
- Radiotherapy - Brachytherapy to the prostate, i.e. radioactive iodine-125 seeds (advice from the ISBN 978 903613 49 8, UK Guidance on Radiation Protection Issues following permanent Iodine-125 Seed Prostate Brachytherapy Report 106, states that cremation can be carried out normally after 20 months have elapsed since the seeds were implanted, based on a 145Gy permanent seed implant in the prostate and 25% residual activity remaining in the remains after the cremation process). Cremation is not recommended until 20 months after the seeds were implanted and scattering of ashes is not recommended until 22 months after the seeds were implanted, with the ashes strewn over an area of not less than 1 square mile.

Dental mercury amalgam is not required to be removed from a deceased person prior to cremation, as environmental legislation requires that crematoria abate (filter) mercury emissions from 50% of cremations. Dental amalgam therefore is not required to be recorded as an implant.

If you require more information about implants, it can be accessed through the link below (particularly Annex A).

<http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>³⁶.

To prevent further distress to the bereaved, you should respond promptly to any reasonable queries from the crematoria, to the best of your knowledge and belief.

³⁶<http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>

COPFS expects you to report only those infectious deaths, which pose an acute and serious public health risk, not all cases. If you are unsure, you can contact your Public Health Department for advice. Alternatively, you could contact the PF for advice. However, telephoning for advice does not mean that you have reported a death to the PF. If the PF decides that the death should be reported, you will have to complete the necessary forms to report the death to the PF.

Mortuary staff in hospitals and funeral directors should be made aware of hazards that could pose a risk to them or relatives who handle the body of the deceased, without breaching patient confidentiality.

7.7 Stillbirth

The Stillbirth Register is separate from the Register of Births and the Register of Deaths and is not covered by the new medical review system.

You or the midwife, whoever has attended the delivery, can sign a stillbirth certificate. The stillbirth should be registered within 21 days of the delivery. Some stillbirths require to be reported to the PF in accordance with the [PF guidance](#)³⁷. e.g. if no clinician attended the delivery or if the stillbirth is sudden, unexplained or unexpected. If unsure, the case must be discussed with the PF and subsequently the appropriate forms completed to report to the PF if required to do so by the PF. The certificate of stillbirth (Form 6 in Annex 1) has been updated.

Fetuses born dead before 24 weeks are not registered. In this instance, there are no statutory forms currently required to be completed, and the family are not required to register the death with the registrar. However, the health authority has to give confirmation to the next of kin, that a pregnancy loss had taken place. The cremation authority requires a statement that the “Health Authority/medical practitioner confirm that the pregnancy has ended”. When the next of kin applies for the burial or cremation, this confirmation will be submitted to the burial or cremation authority. This excludes a fetus that was delivered after 24 weeks but which was dead in utero before 24 weeks, which is considered to be a “stillbirth”. However, in the future, there may be a requirement to complete statutory forms for “non-viable” fetuses born before 24 weeks and who do not show any signs of life.

³⁷<http://www.copfs.gov.uk/publications/deaths>

A baby who has shown signs of life after birth is considered live-born for registration purposes, irrespective of the number of weeks of the duration of the pregnancy. In these cases, a birth certificate should be issued. You should complete an MCCD (see section 5.9 regarding Neonates), or discuss the death with the PF, if the circumstances of the death are appropriate as in the [PF guidance](#)³⁸.

Scotland is unusual in using an “adult” certificate for stillbirths, as the rest of the UK use a specific WHO perinatal death certificate.

Example

Ia Unexplained

Ib Intrauterine Growth Restriction

Ic Placental Dysfunction

Id Unknown Cause

8. **REPLACEMENT MCCDS**

Replacement MCCD should be provided only in **exceptional** circumstances, such as the rare situation where a certifying doctor is unavailable, for a significant length of time, to correct errors in the MCCD to enable the satisfactory completion of the registration of the death.

Reasonable differences of clinical opinion should not be a cause to provide a replacement MCCD. NRS is of the view that the original certifying doctor always should undertake any changes, by revision or replacement, required to be made to the original MCCD. If significant errors need to be corrected, a replacement MCCD may be provided by another doctor in rare circumstances, by asking another doctor to step in to the certifying doctor’s place e.g. the certifying doctor has left the country for a long time, is incapacitated (including suspensions), or is deceased. Sometimes a clinical member of the team with knowledge of the patient and/or access to the clinical records may be asked by the registrar to provide information/clarification of simple (minor) administrative queries/errors/omissions (as described in the second example below). Examples of some situations, which may arise, have been included below for clarification.

³⁸<http://www.copfs.gov.uk/publications/deaths>

- The sort of errors for which registrars regularly send informants back to the original certifying doctor include missing signatures, blank or incomplete causes of death, and clearly out of order sequence of events for the cause of death. The certifying doctor will provide a revised or replacement MCCD, including a signed and dated note or email specifying the amendments to the MCCD, or signed and dated annotations on the original MCCD. If the certifying doctor is not available, the revised or replacement MCCD, including a signed and dated note or email specifying the amendments to the original MCCD, , may be provided by another doctor who has knowledge of the deceased and/or has access to the relevant clinical records as a contingency provided by the system.
- In many cases where an MCCD is not selected for a review, registrars can assess the MCCD as lacking some detail in the administrative (non-clinical) information e.g. postcode missing. In these circumstances, rather than inconveniencing the family, the registrar will phone the certifying doctor to clarify the proper intent and correct this on the original MCCD. When registrars amend administrative data on the MCCD, to prevent the form from being sent back to the certifying doctor, it is always at the explicit instruction, and with the explicit permission, of the original certifying doctor. It would **not** be legally compliant if a member of the clinical team with knowledge of the patient and/or access to the clinical records instructs the registrar to amend an MCCD if the actual certifying doctor is available somewhere, **no matter how challenging it maybe to contact the doctor**; but it would be legally compliant if the certifying doctor is genuinely unobtainable for the reasons given above.
- Where an MCCD is under review and substantial changes, or a replacement MCCD is required by the MR, NRS would accept a revised MCCD (such as a signed and dated note or email amendment to the original MCCD, or a signed and dated annotation on the original MCCD), or a replacement, from the certifying doctor. NRS would also accept such a revised MCCD or a replacement from another qualified medical practitioner, who has knowledge of the deceased and/or has access to the relevant clinical records, if the original certifying doctor is unavailable (moved away, deceased, etc.). **Registrars are not allowed to make any alterations to the clinical parts of the MCCD, even at your direction, without a written confirmation of the change/s required.** In such situations, for the benefit of the system records and the district examiners who scrutinise each entry after registration of the death, registrars will put a note into their Forward Electronic Register (FER) system, about the changes made. This includes the fact that the MCCD had been revised or replaced by another appropriate doctor, as the original certifying doctor was unavailable to undertake the

changes required by the MR. This is the same situation if changes are required for an MCCD which is not selected for review

9. **CHANGING THE PUBLIC RECORD OF THE CAUSE OF DEATH**

As mentioned in section 5.3, NRS may ask you to provide additional information about the causes of the death. This is solely to enable NRS to classify the death accurately for the purpose of the statistics that it produces. NRS does not change the public record of the cause of the death based on the information that you provide in response to its requests.

There are only two ways in which the public record of the cause of a death can be changed.

Firstly, following the report of the death to the PF, if further clinical investigations after the PF instructed post mortem examination change the initial cause of death, the PF will advise NRS what the amended cause of the death should be. The procedures in place for how this is done can be obtained from NRS.

Secondly, a doctor may complete a second MCCD for the death as below.

To change the public record of the cause of a death, you should complete a replacement MCCD in respect of the death, and send the form to the local registration office. This replacement form should be annotated across the top with "Replacement for MCCD " and include the original MCCD serial number, if known. The registrar will then arrange for the local office record of the death to be changed, and pass the information on to NRS, who will update its records. NRS will also inform the person who registered the death that the cause of the death has been changed, and how to obtain revised copies of the certificate of the registration of death.

In these circumstances, any doctor can complete a replacement MCCD in respect of a particular death, and it does not have to be done by the doctor who originally certified that death. Therefore, for example, a Specialist in charge of the care of the deceased may complete a second MCCD related to a death that was originally certified by a doctor undertaking postgraduate training and who has now moved to another hospital.

You should only complete a second MCCD in cases where you believe that the change in the cause of death is likely to be regarded as "significant" by the relatives or by another

interested party (such as an insurance company). **Please do not complete a second MCCD if the change is one that most people would be likely to regard as "minor"** (e.g. to specify more precisely the type of cancer, or to correct a grammatical mistake), **unless you believe that making the change is important to the relatives or to another interested party**. Changes, which have to be made to improve the accuracy of the mortality statistics, without altering the public record of the cause of death, should be specified either in your responses to enquiries from NRS or by writing to the NRS Vital Events Statistics branch (at Ladywell House, Ladywell Road, Edinburgh EH12 7TF).

Email: statisticscustomerservices@nrscotland.gov.uk

As mentioned earlier, NRS does not change the public record of the cause of the death based on the information that you provide in response to its requests, because those details are supplied for statistical purposes only. Very occasionally, the nature of such information may make NRS staff consider that there is a case for considering a change to the public record of the cause of the death. If so, NRS may ask you to consider submitting a replacement MCCD in respect of that death. In such cases, it is for you to decide what (if any) changes should be made to the public record, because NRS will not use information that was supplied for statistical purposes to change the public record. Please note that NRS will not suggest that you complete a replacement MCCD in cases where the death was reported to the PF, because NRS will expect the PF to indicate any changes that should be made to the public record of the causes of those deaths.

RELEVANT FORMS

MCCD (Form 11)



MCCD RECORD OF ISSUE



CURRENT CERTIFICATE OF STILLBIRTH (Form 6)



CERTIFICATE OF REGISTRATION OF DEATH (Form 14)



COPY OF REGISTER PAGE



Register Page -
Death.pdf

CERTIFICATE OF REGISTRATION OF STILLBIRTH (Form 8)



Death
Certification - F...

THE QUALITY ASSURANCE AND REVIEW OF MCCD

The [Certification of Death \(Scotland\) Act 2011](#)³⁹ is intended to improve the quality of MCCDs through quality assurance of the MCCD undertaken by an independent medical review system.

The aims of the legislation are to implement a new death certification system in Scotland which will introduce a single system of independent effective scrutiny, applicable to all deaths that do not require to be reported to the Procurator Fiscal; to improve the quality and accuracy of MCCDs; to strengthen clinical governance in relation to deaths; and to provide improved public health information.

There are two levels of random independent reviews of the MCCD

Level 1 - a basic shorter review of currently 10% of eligible deaths

Level 2 - a comprehensive review of about 2,000 deaths per year (around 4%)

The MCCDs for review will be selected at random by NRS, at the time the death is registered by the informant. You are required to complete the MCCD promptly as death registration cannot be finalised until the review process has been completed. The review will normally be completed in one working day (for Level 1 reviews) or 3 working days (for Level 2 reviews), depending on the level of the review. An MCCD may also be selected for review “for cause” by a MR, where an MCCD may be identified by the MR, SMR, or through other intelligence (for example data trends, feedback from registrars, Scottish Government). A review may also be undertaken following consideration of a request by an interested party such as a family member (Interested Persons Review – see paragraph 8 below). Further information, including the Scottish Government guidance, is also available on the [relevant sections](#)⁴⁰ of the Scottish Government website.

1. Medical Reviewer (MR)

³⁹ http://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf

⁴⁰ <http://www.gov.scot/Topics/Health/Policy/BurialsCremation/Death-Certificate>

The reviews will be undertaken by MRs, under the supervision of a Senior Medical Reviewer (SMR), all of whom are employed by Healthcare Improvement Scotland (HIS), and supported by Medical Reviewer Assistants (MRAs). As specified in legislation, the statistical analysis will be undertaken by a statistical team. This team is part of NHS Information Services Division (ISD).

2. Level 1 reviews

The main purpose of Level 1 review, which is a shorter review, is to improve the quality of the MCCD, for deterrence of poor and mal practice, and for public reassurance. In a Level 1 review, the MR will check the cause of death, and query anything unusual. This involves checking the MCCD, including checking the GMC registration and CHI number, looking at Emergency Care Summary (ECS) summary and speaking to the certifying doctor (or another doctor in the team, with knowledge of the deceased and/or access to the relevant clinical records). This is usually done by telephone to obtain background clinical information.

Level 1 reviews will allow for any discrepancies to be picked up and can act as a trigger for a comprehensive Level 2 review. Some of the criteria for upgrading include:

- non-standard cause of death stated
- the sequence for the cause of death does not appear to be logical
- the registrar has referred an individual case for review where they have stated a particular concern about the medical cause of death
- feedback from ISD of relevant trends.

In the rare circumstances where no such other doctor is available, the MR will refer the case to the SMR.

3. Level 2 reviews

This thorough more comprehensive review of all available information allows the MR to come to a view about whether or not the MCCD is “in order” and provides information for the quality improvement programme for the new death certification system, while also providing a level of deterrence.

The checks include reviewing the MCCD and speaking to the certifying doctor (or another doctor in the team), usually by telephone, to obtain background clinical information. In addition, the MR will consider relevant documents associated with the death, including appropriate health records, and the results of any clinical investigations. The case may be discussed with other relevant clinical and health care staff, as required. The MR may also discuss the case with the family of the deceased or an informal carer, if required, through the most suitable means such as, telephone, face-to-face, or electronic methods of communication. In addition, the legislation does not prevent the MRs and SMR considering other relevant evidence, such as viewing the body (this will extremely rarely be necessary).

If when trying to discuss a certificate, the relevant medical practitioner is unavailable or incapacitated, the MR will discuss the MCCD with another doctor in the team with knowledge of the case and access to the clinical records. In the case of doctors in postgraduate training, this should be another doctor in the team with knowledge of the case and access to the clinical records, or with a senior doctor who is the relevant Medical/Clinical/Educational Lead. In the rare circumstances where no such other doctor is available, the MR will refer the case to the SMR.

If, after conducting a review, the MR has come to the view that the MCCD is not in order, and the relevant medical practitioner is unavailable or incapacitated to provide a replacement certificate, the MR will agree a replacement MCCD with another doctor who has knowledge of the deceased and/or has access to the relevant clinical records. The review can then be completed without the need to refer the case to the SMR.

Under [Section 14 of the 2011 Act](#)⁴¹, the MR can “require any person who is able, in the opinion of the Medical Reviewer, to produce relevant documents (including health records), to do so”.

4. Medical Reviewer Assistant (MRA)

MRs will be assisted in their duties and tasks by non-clinical administrative staff, the MRAs. The MRA will prepare the randomised MCCD by NRS for review. This will involve setting up the conversation between the MR and the certifying doctor, and additional preparatory work for Level 1 and Level 2 reviews.

⁴¹ <http://www.legislation.gov.uk/asp/2011/11/section/14>

The MRAs will be the first point of contact for queries for the MR office and organise the work of the MRs. MRAs will also arrange for the transfer of medical records, obtaining documents, setting up meetings between relevant people and the MRs and gathering other relevant information for the MR. MRAs will link closely with local authority registrars, NRS, the funeral directors and the Procurator Fiscal Offices.

The MRA will ensure that ISD receives reports required for monitoring purposes. The MRA will be responsible for the management of any clinical records and other data used for the review, as well as the safe retention and destruction of any patient identifiable information held by them, in accordance with ["A guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in Scotland"](#)⁴².

5. Senior Medical Reviewer (SMR)

The SMR will review any certificates where the MR is of the opinion the MCCD is not in order, and the certifying doctor is unable or unwilling to provide a replacement certificate, or if there is any ongoing disagreement between the MR and the certifying doctor, or in rare instances there is no doctor to provide information on the relevant case.

The SMR also provides any advice and guidance to the MRs as necessary.

If the MR identifies any concerns around quality and behaviour of a doctor when conducting a review, the MR and the SMR, where appropriate, will bring these to the attention of the Medical Director/Clinical Director of the relevant Health Board and/or the relevant Responsible Officer for the GMC. The MR and the SMR will request confirmation that the concern has been discussed with the certifying doctor and what action has been taken.

ISD statisticians will also provide the MRs, SMR and the Medical Directors of Health Boards with statistical information on death data for the relevant Health Board area/s. MRs will use this data to identify any additional cases for review based on triggers such as missing data, and incorrect forms. These clinical governance issues will also be discussed with the

⁴² <http://www.gov.scot/Publications/2012/01/10143104/0>

relevant Medical Director/Clinical Director of the Health Board and/or the relevant Responsible Officer for the GMC.

When conducting the review, the SMR will reflect on the links to clinical governance processes of NHS Boards, and record and reflect on any themes, which arise from the different types of reviews. These could include recurrent quality issues in certain areas of certification or evidence that practice may be in need of review in certain departments, hospitals or GP practices. The SMR will also note his/her views on any training issues in relation to completion of MCCDs. The SMR will bring this to the attention of the relevant Medical Directors (or appropriate other officers) of the Health Boards. Death certification could be one of the areas included in the annual appraisal discussion of doctors.

The SMR will provide an annual report for each financial year to the Scottish Government, which is published subsequently. The report includes the activities of medical reviewers and the senior medical reviewer during the year, and other information required by Scottish Ministers. These include numbers of Level 1 and Level 2 reviews, advance registration requests, “for cause” reviews, and repatriations from abroad; number and type of educational events/activities; and feedback from stakeholders.

6. *Unsatisfactory reviews*

If the review with the MR is satisfactory, the electronic Case Management System (eCMS) used by the MRs and SMR, will trigger a real time update to the registrar’s FER system. The registrar will complete the registration process and issue Form 14 to the informant or the funeral director to enable the funeral to proceed.

If however, the MR decides that the MCCD is not in order, the MR will request that a replacement MCCD be issued by you, as the certifying doctor, with the agreed corrections, or a signed and dated note or email with the additional amendment to the original MCCD can be sent to the MR, for a further check. The MR will notify you when the check and scrutiny process for the MCCD is completed, so that you can send the original documents usually by courier (replacement MCCD or the note or email with the alterations) to the registrar. The eCMS will trigger a real time update from the MR to the registrar’s FER system. The registrar on receipt of the documents sent by you to her/him, will replace the original MCCD (in the case of a replacement MCCD) or attach the note or email with the amendments to the

original MCCD. Reasonable differences of clinical opinion, even with the MR or SMR **should not** be a cause to provide a replacement MCCD.

If you do not agree to make any corrections, the MR will refer the case to the SMR who will undertake another Level 2 review of the case and contact you. If you and the SMR agree that some changes are required, the process followed will be as in paragraph above. If however, you do not agree with the SMR, the SMR will complete the review and the eCMS will trigger a real time update to the registrar's system, which will allow the registrar to proceed with registration based on your original MCCD. The incident will be reviewed as a case study or a significant event and if appropriate, brought to the attention of the Clinical/Medical Director of your Health Board and their clinical governance procedures. MCCD reviews (positive reviews and learning needs) may be included in the doctor's appraisal and revalidation processes.

Please note that an MR must report any suspicion of criminality arising from the review to the PF, under [Section 16 of the 2011 Certification of Death \(Scotland\) Act 2011](#)⁴³.

If the MR or the SMR is of the view that the death is not one under Section 16 as above, but is otherwise reportable to the PF, the certifying doctor should then report this death to the PF after being advised to do so by the MR.

Training resources for doctors are available [from HIS](#)⁴⁴, and information for non-certifying staff developed and the public is available [from NHS inform](#)⁴⁵ and [NHS Education for Scotland](#)⁴⁶. These are accessible through appropriate formats and routes.

7. Post mortem examinations

MRs and SMR do not have the powers to request or require a post mortem examination on individuals who have died in the UK. Post mortem examinations can only be required by the [PF in deaths reported to them](#)⁴⁷. Hospital staff can also undertake post mortem

⁴³ <http://www.legislation.gov.uk/asp/2011/11/section/16>

⁴⁴http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/educational_support.aspx

⁴⁵<https://www.nhsinform.scot/care-support-and-rights/death-and-bereavement/practical-advice-after-a-death>

⁴⁶<http://www.scotlanddeanery.nhs.scot/your-development/death-dying-and-bereavement/medical-certification-of-cause-of-death-mccd/>

⁴⁷ <http://www.legislation.gov.uk/asp/2011/11/section/16>

examinations if clinically indicated, in non-PF cases, with the authorisation (consent) of the next of kin/person with the power of attorney/executor of the will.

MRs and SMR can only agree to a request for a post mortem examination in some relevant cases of people who have died abroad and have been repatriated to Scotland. This is set down in Section [19\(1\) of the Certification of Death \(Scotland\) Act 2011](#)⁴⁸. In this situation, the MRs/SMR may access electronic records of the deceased and contact the person's General Practitioner or relevant hospital clinician for clinical details, prior to making a decision.

8. "Interested Persons" reviews

[Section 4 of the Certification of Death \(Scotland\) Act 2011](#)⁴⁹ allows specified "Interested Persons" to request the MRs for a review of the MCCD if they satisfy certain criteria laid down in legislation e.g. they come within the definition of "[Interested Person](#)⁵⁰"; that the death did not occur more than three years previously; that it does not pre-date the implementation of the 2011 Act (13 May 2015); and that a review has not already been conducted on an eligible MCCD, as below.

The "Interested Person" will be advised by the MR/SMR to use other appropriate processes, e.g. the NHS Complaints procedures, for issues outside the remit of the review system, such as concerns regarding the care of an individual.

9. Not Staying Registration – (Expedited process for reviews) – Advance Registration

An informant may apply for the review to "not stay registration" (expedited process for review) under sections [6 and 7 of the Certification of Death \(Scotland\) Act 2011](#)^{51/52}. An application must be made to the MR before the review is complete, by a form available from the registrar. If the request is granted within 2 hours, registration of the death may go ahead if the MCCD is considered by the MR to be "in order", while the full review continues to be carried out. This will allow the burial, cremation, or other methods of disposal of the deceased person's body. If the informant requests an expedited review, this must be under one or more of the following categories:

⁴⁸ <http://www.legislation.gov.uk/asp/2011/11/section/19>

⁴⁹ <http://www.legislation.gov.uk/asp/2011/11/section/4>

⁵⁰ <http://www.legislation.gov.uk/asp/2011/11/section/4>

⁵¹ <http://www.legislation.gov.uk/asp/2011/11/section/6>

⁵² <http://www.legislation.gov.uk/asp/2011/11/section/7>

- for **religious or cultural reasons** - for example, some religious traditions require burial within 24 hours and some communities have a tradition of burial within three days
- for **compassionate reasons** - for example, in the death of a child under 16 years where a delay may cause significant additional distress
- for **administrative or practical reasons** - for example, where the family does not reside in Scotland and the deceased will be in transit to another part of the UK or international destinations for a funeral

10. Repatriated bodies from outside the UK

If a person dies outside the UK and is to be buried, cremated or undergo other processes allowed within legislation in Scotland, HIS is required [under sections 17-19^{53/54/55}](#) of the Certification of Death (Scotland) Act 2011 to verify a foreign death certificate, confirm the identity of the deceased, and check other relevant papers. MRs can then authorise cremation, burial or other processes allowed within legislation in Scotland.

MRs can also request or agree to a post mortem examination.

The applicant can be:

- a person who wishes to arrange the interment, cremation or disposal by other means of the deceased; or
- the person in charge of the place where the deceased is to be interred, cremated, or disposed of by other means.

The MR has to undertake a review, such as contacting the GP practice where the deceased was registered or the Consultant in charge of the care in Scotland prior to death. The MR must provide an authorisation to dispose, including to cremate, including information of “hazards” for cremation and the handling of the body. In the unusual circumstances where the cause of death is not known, despite all the enquiries, the MR can request a post mortem examination. The PF has jurisdiction to investigate particular categories of deaths abroad.

[Section 6 of the Inquiries into Fatal Accidents and Sudden Deaths etc. \(Scotland\) Act 2016⁵⁶](#) allows for Fatal Accident Inquiries (FAIs) to be held in certain circumstances where a person who normally lives in Scotland dies abroad. Examples of this include deaths as a result of

⁵³ <http://www.legislation.gov.uk/asp/2011/11/section/17>

⁵⁴ <http://www.legislation.gov.uk/asp/2011/11/section/18>

⁵⁵ <http://www.legislation.gov.uk/asp/2011/11/section/19>

⁵⁶ <https://www.legislation.gov.uk/asp/2016/2>

an act of terrorism and the deaths of certain categories of UK armed forces personnel serving abroad.

11. Pandemic Flu

The [legislation](#)⁵⁷ enables the scrutiny process to be suspended in certain circumstances such as epidemics or pandemics, such as Pandemic Flu.

[Death Certification during an Influenza Pandemic](#)⁵⁸ has been provided regarding death certification in the event of pandemic flu

12. NRS feedback to Health Boards

NRS sends datasets weekly to Health Boards, which include: the names and addresses of the deceased, the certifying doctor and the deceased's own doctor; the description of the cause of death (as given in Part I), plus all the ICD10 codes which NRS has allocated (including any based on Part II); and other information from the MCCD and the death registration process. Some of what you provide is held in a coded form in five variables called -

DICDSUPP0, DICDSUPP1, DICDSUPP2, DICDSUPP3 and DICDSUPP4.

For example, where any one of these variables has a code 12, the "M1 box" would have been ticked by the certifying doctor. Similarly, a code 13 indicates that the "M2 box" has been ticked. This will enable Health Boards to track certain deaths in their areas such as deaths related to pregnancy.

The Statistician, Vital Events Statistics, at NRS is happy to be contacted for further details of what NRS provides to Health Boards at the address and email below:

Statistician, Vital Events Statistics, National Records of Scotland Ladywell House, Ladywell Road, Edinburgh | EH12 7TF

Email: statisticscustomerservices@nrscotland.gov.uk

<http://www.gro-scotland.gov.uk/enquiries.html>

⁵⁷ <http://www.legislation.gov.uk/asp/2011/11/section/2>

⁵⁸ <http://www.gov.scot/Topics/Health/Policy/BurialsCremation/Death-Certificate/Influenzapandemic>

MESOTHELIOMA PRO FORMA



Mesothelioma Pro
Forma - CMO Letter



Mesothelioma Pro
Forma - 17 March 20

RELEVANT LINKS

- Access to Health Records Act 1990 -
<http://www.legislation.gov.uk/ukpga/1990/23/section/3>
- Battery powered and other implants that could cause problems during cremation (Annex A)
<http://www.justice.gov.uk/downloads/burials-and-coroners/cremations/cremation-applicants-guidance.pdf>
- General Medical Council (GMC) website
<https://www.gmc-uk.org/>
- GMC Good Medical Practice
<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>
- Guidance on Part 2 - Notifiable Diseases, Notifiable Organisms and Health Risk States of The Public Health etc. (Scotland) Act 2008
<http://www.scotland.gov.uk/Topics/Health/Policy/Public-Health-Act/Implementation/Guidance/Guidance-Part2>
- Healthcare Improvement Scotland (HIS) has developed some educational resources
http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/educational_support.aspx
- NHS Education for Scotland (NES) has produced educational resources to support both certifying and non-certifying staff
<http://www.scotlanddeanery.nhs.scot/your-development/death-dying-and-bereavement/medical-certification-of-cause-of-death-mccd/>
- National Records of Scotland (NRS) link – registering a death
<https://www.nrscotland.gov.uk/registration/registering-a-death>
- NHSScotland Guidance on Patient Confidentiality
<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality>
- Paragraphs 70-72 GMC Guidance on Confidentiality
http://www.gmc-uk.org/static/documents/content/Confidentiality_-_English_0414.pdf
- PF Guidance - “Reporting Deaths to the Procurator Fiscal, Information and Guidance for Medical Practitioners”
<http://www.copfs.gov.uk/publications/deaths>

- Outline Guidance for the provision of Medical Certificate of Cause of Death (MCCD) out of hours (weekends and public holidays only) in exceptional circumstances in primary care and specialist settings and the interface with the death certification review service
<https://www.gov.scot/Resource/0051/00517435.pdf>
- Registration of Births, Deaths and Marriages (Scotland) Act 1965
<http://www.legislation.gov.uk/ukpga/1965/49>
- Relevant sections of the Scottish Government website
<http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>
- Section 4 of the Certification of Death (Scotland) Act 2011
<http://www.legislation.gov.uk/asp/2011/11/section/4>
- Specific guidance Chief Medical Officer Directorate and Police and Community Safety Directorate of the Scottish Government
<http://www.scotland.gov.uk/Resource/Doc/1094/0053368.pdf>
- The Certification of Death (Scotland) Act 2011 website
<http://www.scotland.gov.uk/Topics/Health/Policy/BurialsCremation/Death-Certificate>
- Mesothelioma Pro Forma
<http://www.sad.scot.nhs.uk/media/15671/cmo-pfs-mesothelioma-pro-forma-final-version-v2-18-march-2014.pdf>
[http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)07.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)07.pdf)
- The HSE guidance - Controlling the risks of infection at work from human remains - A guide for those involved in funeral services (including embalmers) and those involved in exhumation
<http://www.hse.gov.uk/pUbns/priced/hsg283.pdf>
- The legislation enables the scrutiny process to be suspended in certain circumstances such as epidemics or pandemics, such as Pandemic Flu
<http://www.legislation.gov.uk/asp/2011/11/section/2>
- The list of notifiable diseases is contained in Schedule 1, part 1 of the Public Health etc. (Scotland) Act 2008 (page 82)
http://www.legislation.gov.uk/asp/2008/5/pdfs/asp_20080005_en.pdf
- Under sections 6 and 7 of the Certification of Death (Scotland) Act 2011
<http://www.legislation.gov.uk/asp/2011/11/section/6>
<http://www.legislation.gov.uk/asp/2011/11/section/7>
- Under Section 14 of the 2011 Act <http://www.legislation.gov.uk/asp/2011/11/section/14>
- Under Section 16 of the 2011 Certification of Death (Scotland) Act 2011
<http://www.legislation.gov.uk/asp/2011/11/section/16>
- Under sections 17-19 of the Certification of Death (Scotland) Act 2011
<http://www.legislation.gov.uk/asp/2011/11/section/17>

<http://www.legislation.gov.uk/asp/2011/11/section/18>

<http://www.legislation.gov.uk/asp/2011/11/section/19>