Independent Healthcare Providers Network

April 2020

Guide to Certification and Notification of Deaths

Who can certify a death?

- In an emergency period, any doctor can complete the medical certificate cause of death (MCCD), when it is impractical for the attending doctor to do so. This may, for example, be when the attending doctor is self-isolating, unwell, or has pressure to attend patients. In these circumstances, it may be practical to allow a medical examiner or recently retired doctor returning to work to complete the MCCD.
- For the purposes of the emergency period, "in attendance "may be in person, via video/visual consultation, but not audio (e.g. via telephone). The certifying doctor should also have access to relevant medical records and the results of investigations.
- There is no provision in the emergency period to delegate this statutory duty to any non-medical practitioner.

Cause of Death and referring deaths to the Coroner

- Covid-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death
- Covid-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.
- That Covid-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status.

Medical practitioners are required to certify causes of death "*to the best of their knowledge and belief*"; they are not expected to be infallible. Even without any changes to the law, there is increased scrutiny of death certification and patterns of mortality by local and national agencies as a result of the Shipman Inquiry.

There has been relaxation of existing regulations around the notification of death by doctors to allow a registered medical practitioner who may not have seen the deceased to certify the cause of death, without a requirement to refer the death to a coroner, as they would usually. However, the requirement for any medical practitioner to have been "in attendance" of the deceased currently remains.

Without diagnostic proof, if appropriate and to avoid delay, medical practitioners can circle '2' in the MCCD ("*information from post-mortem may be available later*") or tick Box B on the reverse of the MCCD for ante-mortem investigations. For example, if before death the patient had symptoms typical of COVID19 infection, but the test result has not been received, it would be satisfactory to give 'COVID-19' as the cause of death, tick Box B and then share the test result when it becomes available. In the circumstances of there being no swab, it is satisfactory to apply clinical judgement.

Deaths occurring during an operation, or before full recovery from an anaesthetic should also be referred In addition, there will always be cases which may on one view be 'natural' which have some other element (e.g. neglect concerns) which brings them within the orbit of the coroner.

Deaths for which the cause is not known must be reported to the coroner.

Strictly speaking, the law requires that an MCCD should be completed even when a death has been referred to the coroner. This is because if the coroner decides not to investigate, the registrar will need to obtain an MCCD from a doctor who attended the deceased before the death can be registered.

Avoid reference to 'natural causes', 'old age', 'oxygen failure', physical and mental conditions which are not fatal in themselves, or terminal events, modes of dying and other vague terms

Cremation form

The Coronavirus Act 2020 has changed the way death certification and cremation are managed for the duration of the outbreak in England and Wales. Cremation no longer requires the confirmatory medical certificate (cremation form 5), but still requires the completion of the medical certificate (cremation form 4).

Form Cremation 4 can be completed by a registered medical practitioner with a licence to practise with the General Medical Council. This includes those who hold a provisional or temporary registration with the General Medical Council. In the hospital care setting it is sufficient to meet the requirement that you completed the medical certificate cause of death or, where you did not complete the medical certificate cause of death that you met the attendance criteria for completing the medical certificate cause of death. Namely, that you have seen the deceased during the course of the last illness within 14 days before death.

Hazard Notification

To help with the exchange of appropriate and sufficient information, Appendix 1 provides a template for the type of information that should be provided with the deceased – this is known as the hazard notification sheet.

The hazard notification sheet is one way of providing those who will handle the deceased with the necessary information to do so safely. It is intended to highlight hazards associated with the deceased, which can include infection risk, implantable devices and radioactive sources. As the information is of a personal nature, it should be handled sensitively and shared only with those who need it to carry out an appropriate risk assessment and to enable appropriate precautions to be taken.

In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign the hazard notification sheet. Where a post-mortem examination has been undertaken, the pathologist (or qualified APT) is asked to sign. The form should be updated by the APT in the light of any further relevant information made available during the examination.

CQC Notification

Whether or not a death is COVID-19 related, the CQC still require notification of deaths to be completed without delay. This can be done via the notification form enclosed or via the Registered Managers CQC portal access.

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APPENDIX 1 – Hazard Notification Sheet

1	Name of deceased			
2	Date and time of death			
3	Source (hospital, ward or other)			
4 Infection risk from the deceased[1]				
4a	Does the deceased present an infection risk? (Ring as appropriate)			
	Yes	Suspected	None suspected	
4b	If yes, what are the likely routes of transmission? (Ring all that apply)[2]			
	Airborne	Droplet	Contact	
4c	Infection (if permitted to disclose)[3]			
4d	Provide any relevant information to enable the deceased to be handled safely[4]			
5 Condition of the deceased[5]				
5a	Is the deceased leaking body fluids? Please provide details			
5b	Have accessories that present a risk of sharps injury been removed?			
5c	If yes, have the puncture points been covered or sealed?			
5d	If no, please provide details and location			
5e	Does the deceased have an implantable device? (Ring as appropriate)			
	No	Yes and switched off	Yes but not switched off	
5f	If yes, please provide details and location			
5g	Was the deceased receiving radiotherapy? (If yes, please provide details)			
6	Signed[6]			
	Print name			
	Institution			

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This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc Act 1974). This form provides one means of sharing the pertinent information.

Notes

1. Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

2. When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3. If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4. In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (eg embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

5. In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, eg sharp medical devices or implantable devices (eg pacemakers), their location and whether they need to be removed. 6 In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (eg community setting), the doctor with knowledge of the deceased's condition is asked to sign.

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APPENDIX 2 – Care of the Deceased Guidance

This guidance must be used in conjunction with the providers own policies including Care of the Dying and After Care Policy.

The principles of Standard Infection Control Precautions and Transmission Based Precautions continue to apply whilst deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact.

Staff must wear the PPE that is designated as appropriate for the clinical environment which the patient is as per PHE guidance:

Body bags are not required in terms of COVID-19 risk, but may be required for other, practical reasons, such as maintaining dignity or preventing leakage of bodily fluids.

Viewing of the deceased should not take place within the hospital and will be facilitated by the local mortuary according to their policy.

Preparing for transport

Staff responsible for wrapping bodies before transport should wear appropriate PPE to minimise exposure to infected bodily fluids, contaminated objects and other contaminated environmental surfaces. You must wear the PPE that is designated appropriate for the clinical environment which the patient is as per PHE guidance.

Environmental cleaning and waste management at site of death site

Regular cleaning followed by disinfection is recommended. Cleaning personnel should use hospital disinfectants active against viruses.

- Patient care equipment should be cleaned according to manufacturer's instructions, and where possible with chlorine-based disinfectant, 70% alcohol or an alternative disinfectant used within the organisations that is effective against enveloped viruses. Where it is not readily amenable to cleaning, such as blood pressure cuffs, it should be disposed of to waste.
- Clean all surfaces, beds and bathrooms with a neutral detergent, followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine.
- Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination and disposed as clinical waste.
- Reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant as described above.
- Communal cleaning trollies should not enter the room.
- Waste should be treated as infectious clinical waste Category B (UN3291) and handled in accordance with healthcare facility policies and local regulations.
- In addition to the above recommendations, cleaning and waste management staff should wear appropriate PPE for the clinical environment.

All COVID-19 related patient deaths must be reported on the national, central COVID-19 Patient Notification System (CPNS).

The system can be accessed via the link below. The death must be reported on this system promptly by the clinician responsible for the patients care or the senior nurse on duty at the time of the patient's death.

https://improvement.nhs.uk/my-nhsi/register/for-app/0oa3qnqnsysTfdclU0i7/

The names and email addresses of these users should also be provided in advance to the Regional Single Points of Contact below to accelerate the account authorisation process:

London	england.london-covid19@nhs.net
South East	england.se-incident@nhs.net
South West	england.sw-incident1@nhs.net
Midlands	england.mids-incident@nhs.net
East of England	england.eastofengland-covid19@nhs.net
North West	england.eprrnw@nhs.net
North East and Yorkshire	england.eprrney@nhs.net

It is vital that all providers with COVID-19 patients in their care – including in mental health trusts, community trusts, independent sector and other providers – use this system to report all COVID-19-related deaths.

Of particular importance in the reporting of deaths is ensuring the NHS number of the patient is known and reported for each patient. Where the NHS number is not known, contact should be made with the Regional Single Point of Contact for a unique reference number.