Notification to HM Coroner, Medical Certification of the Cause of Death, Certification of Stillbirth & Cremation

Policy

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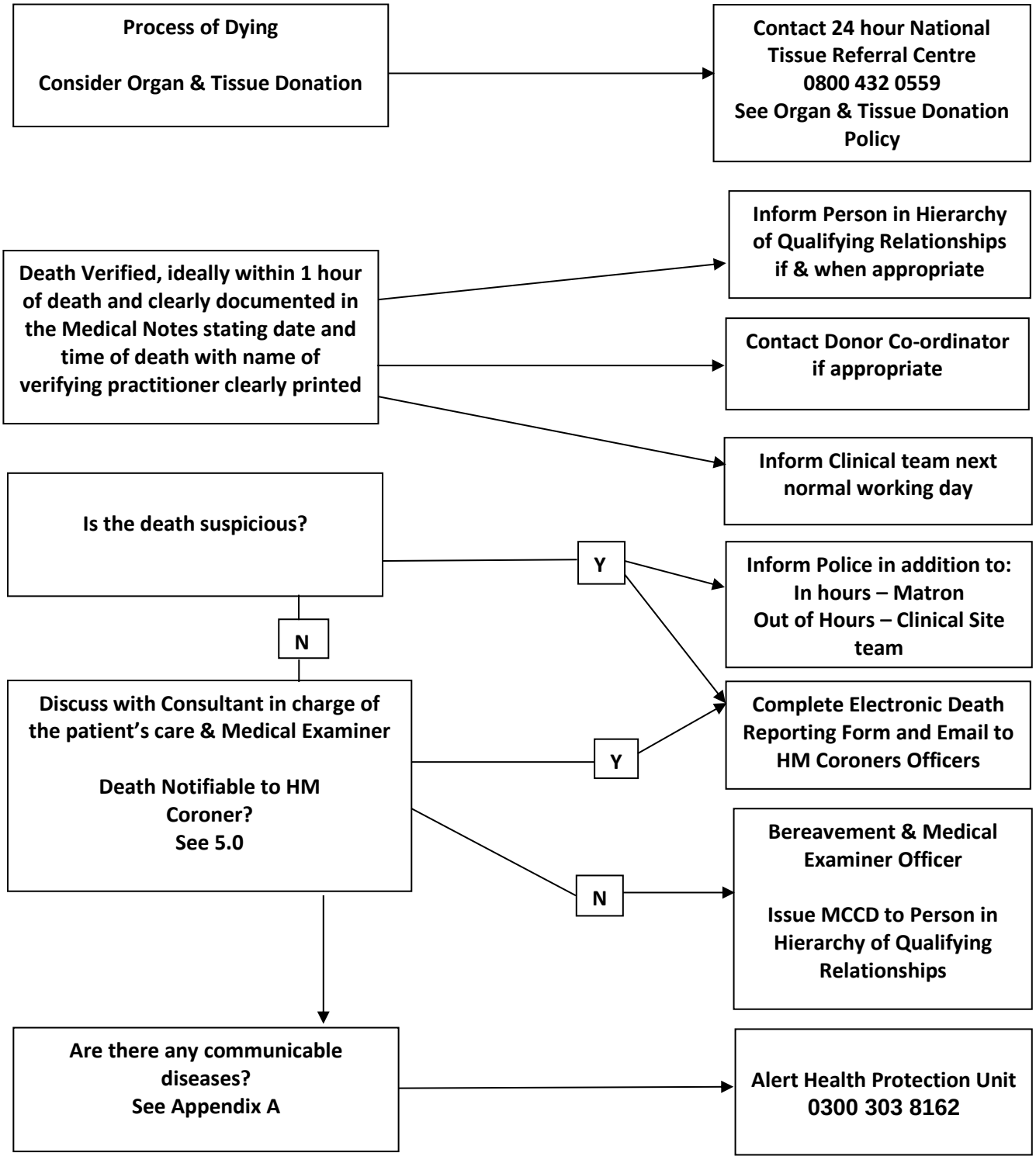
Date of issue	18 November 2021 Minor Amendments 22.03.2023	**Review date**	November 2024
Applies to	All deaths which occur within Somerset Foundation NHS Trust, all deaths before arrival at hospital which come through the Emergency Department and all stillbirths	**Exclusions**	Sections 15.0 - 18.0 not applicable to Community & Psychiatric inpatient areas due to differing existing processes.

CONTENTS

1.0 FLOW DIAGRAM

GENERAL SCHEME OF POLICY



2.0 INTRODUCTION

According to the Births and Deaths Registration Act of 1953, when someone dies a doctor involved in their care must complete a Medical Certificate of Cause of Death (MCCD). The family, someone arranging the funeral, or, where there is no one else who can do it, a representative of the Chief Executive of the organisation where the person died, must arrange for the registration of death with Somerset Registrations. There is a legal obligation to report any death to HM Coroner if it has occurred under any of the circumstances outlined in this policy.

Musgrove Park Hospital is licenced and inspected by the Human Tissue Authority (HTA). We have to demonstrate that effective policies and procedures are in place. For the purposes of this policy the HTA standards are in relation to activities involving consent for removal of tissues/organs, the Post Mortem (PM) process, and the use and storage of human tissue removed through PM.

The purpose of this policy is to ensure that Trust Staff are aware of their statutory responsibilities, so that they can carry out these duties correctly, and that unnecessary errors and delays are avoided for relatives.

Staff must have received appropriate training to undertake duties such as consent for Hospital PM, completing the MCCD and forms for cremation.

In times of Pandemics, temporary changes in legislation may be made. During these times the Bereavement & Medical Examiner Office will be able to inform you if there are any changes in these processes.

Criminal and General Medical Council proceedings have been successfully brought against doctors who have falsely completed the forms

3.0 DEFINITIONS

3.1 **Person in Hierarchy of Qualifying Relationships (PHQR)** – Formerly known as Next of Kin. Persons are ranked in the following descending order:

a) spouse or partner (including civil or same sex partner)
b) parent or child (in this context a child may be of any age)
c) brother or sister
d) grandparent or grandchild
e) niece or nephew
f) stepfather or stepmother
g) half-brother or half-sister
h) friend of long standing

3.2 **Post mortem (PM)** – External and internal examination of a body after death, usually to establish or confirm the cause of death, and perhaps significant conditions contributing to the death but not related to the disease or condition causing it.

3.3 **Medical Certificate of Cause of Death (MCCD)** – This enables registration of the death, which in turn provides a permanent legal record of the fact and cause of death and enables people to make the relevant funeral arrangements.

3.4 **Electronic Death Reporting Form (EDRF)** – sent electronically to HM Coroner's Office.

3.5 **Human tissue authority (HTA)** - The HTA is a regulator set up in 2005 following events in the 1990s that revealed a culture in hospitals of removing and retaining human organs and tissue without consent.

3.6 **Notifiable Diseases –** those diseases where there is a legal requirement that cases are reported to the Health Protection Team at the regional Public Health England (PHE) centre.

3.7 **Notifiable Organisms –** Specific organisms, including multi-resistant organisms, which laboratory staff report to Infection Prevention and Control.

3.8 **SANDS** stillbirth and neonatal death charity.

4.0 ROLES and RESPONSIBILITIES

4.1 **All doctors** have a duty to comply with the law (see introduction). It is the statutory duty of a doctor who has attended the patient in their last illness to issue a MCCD.

4.2 **Consultants in charge of patient care** have a responsibility to discuss the cause of death with the junior doctor completing the documentation relating to the death and, if no junior doctor is available, should identify another doctor who is eligible to complete the paperwork or do it themselves. They also have a responsibility to arrange a non-coronial Hospital PM and consent for it, should it be required.

4.3 **Doctors or Midwives** who are in attendance at a Stillbirth have the responsibility to complete the Medical Certificate of Stillbirth, in compliance with the law.

4.4 **Medical Examiners (ME)** have a responsibility to:

- Scrutinise the patients' medical records to ascertain the circumstances leading up to the patient's death.
- Discuss each case with the certifying doctor prior to the completion of any paperwork including referral to HM Coroner.
- Agree the proposed cause of death and the overall accuracy of the medical certificate of cause of death for **all** deaths which occur within Somerset NHS Foundation Trust.
- Discuss the cause of death with the next of kin/informant and establish if they have any feedback regarding the care or treatment their loved one received.
- Act as a medical advice resource for the local Coroner
- Highlight cases for further review under local mortality arrangements and contribute to other clinical governance procedures.

4.5 **Bereavement & Medical Examiner Officers (B&MEOs)** have a responsibility to ensure compliance with the legal and procedural requirements associated with certification of death, investigation by the coroner and registration of death.

- Where necessary, to support doctors in preparation for their conversation with the Medical Examiner and completion of the necessary paperwork in relation to a natural cause of death.
- To scrutinise the resulting documentation for its correctness.
- To give procedural and emotional support to grieving families and/or friends of the deceased person, in the initial days following the death.
- To explain the cause of death in simple terms using empathy and transparency.
- Discuss the cause of death with the next of kin/informant and establish if they have any concerns about care that could have impacted/led to death
- To be impartial and speak with HM Coroner's Officers if there are concerns not addressed by the process above.
- To represent the CEO of the Trust should there be no other person available to register the death.

4.6 **Lead Bereavement & Medical Examiner Officer** has responsibilities as described in 4.5 and is also responsible for F1 Induction and Foundation training in regard to this policy and correct completion of documentation after death which will ensure compliance with this policy.

4.7 **Anatomical Pathology Technicians (APT)** are to assess, on a case by case basis, whether out of hours body release can be facilitated if it is requested through the Clinical Site team.

4.8 **Mortuary Manager** in the absence of anyone else trained in consenting for a Hospital PM, has a responsibility to be a part of the consenting team, along with the Consultant responsible for the patient's care, provided they have completed the necessary training.

4.9 **His Majesty's Coroner (HM Coroner)** is an independent judicial officer of the Crown who has a statutory duty to investigate the circumstances of certain categories of death for the protection of the public.

4.10 **Head of Patient Safety/Learning from Deaths Lead**: responsible for the management and oversight of trust-wide 'Learning from Deaths' programme, including the project management of the mortality review process, supporting reviewers, analysis of review data, sharing of learning and performance improvement. The LFD Lead will provide advice and support to staff required to provide a Coroner's Report or Witness Statement to assist with the inquest proceedings.

4.11 **Trust Coroner's Liaison Officer**: will support the Head of Patient Safety/Learning from Deaths Lead with the governance administration throughout the inquest process and be the first point of contact for HM Coroner's Office in respect of requesting witness statements/reports and required documents for example, policies and procedures (including Standard Operating Procedures), RCA Investigation reports and completed action plans.

5.0 PROCESS DESCRIPTION

Circumstances in which a notification should be made

A death under any of the following circumstances should always be notified. A death must be notified to HM Coroner where there is reasonable cause to suspect that the death was due to, caused, or contributed to by the following circumstances:

5.1 The death was due to poisoning including by an otherwise benign substance

- This applies to deaths due to the deliberate or accidental intake of poison, including any substance that would otherwise be benign, beneficial or tolerable but at certain levels is detrimental to health, such as sodium (salt).
- In regard to alcohol or smoking related deaths, only those due to acute poisoning should be notified to HM Coroner.
- Deaths due to natural chronic/long lasting conditions (caused by alcohol or cigarette consumption) should **not be** notified to HM Coroner.

5.2 The death was due to exposure to, or contact with, a toxic substance

This applies to any cases where death was due to the exposure to a toxic substance. Examples of this include: Toxic material, including toxic solids, liquids and gases or radioactive material.

5.3 The death was due to the use of a medicinal product, the use of a controlled drug or psychoactive substance

This applies to deaths due to either the deliberate or accidental intake or administration of medicinal products or any other drugs, or any complications arising from this. Examples of this include: Illicit or recreational drugs, medical drugs, including but not limited to, prescribed or non-prescribed medication (e.g. a self-administered overdose or an excessive dose given either in error or deliberately).

Any circumstance where the death may be due to a psychoactive substance should be notified to HM Coroner. A psychoactive substance includes any substance which is capable of producing a psychoactive effect in a person if it affects the person's mental functioning or emotional state. Examples of this include, but are not limited to:

- New psychoactive substances, also known as 'legal highs' or 'designer drugs'.
- Herbal highs, such as salvia.

5.4 The death was due to violence, trauma or injury

A death may be considered due to violence, trauma or physical injury where, for example, the deceased:

- Died as the result of violence, trauma or injuries inflicted by someone else or by themselves.

- Died as the result of violence, trauma or injuries sustained in an accident, such as a fall or a road traffic collision.
- The death was due to self-harm
- This may apply if it is reasonable to suspect that the deceased died as the result of poisoning, trauma or injuries inflicted by his/herself or his/her actions**.**

5.5 The death was due to neglect, including self-neglect

- Neglect applies if the deceased was in a dependent position (e.g. a minor, an elderly person, a person with a disability or serious illness) and it is reasonable to suspect that there was a failure to provide them with – or to procure for them – certain basic and obvious requirements. This would include, for example, a failure, omission or delay by any person to provide or procure:

  • Adequate nourishment or liquid.

  • Adequate shelter or warmth.

  • Adequate medical assessment, care, or treatment.
- This also includes a death, albeit from natural causes, where it is reasonable to suspect that the death results from some human failure, including any acts/omissions.
- Self-neglect applies if the death is a result of the deceased intentionally or unintentionally not preserving their own life. However, this does not include circumstances where there has been a documented, reasonable and informed decision by the deceased not to act in a way that would have preserved their own life. This may include a decision not to take a certain course of treatment. There may be cases where people fail to take adequate nourishment or proper personal care due to the natural progression of an underlying illness, such as dementia. Although this may hasten their death, this death should not be notified to the coroner unless there was neglect by others.
- It **does not** extend to deaths where the lifestyle choices of the deceased – for example, to smoke, eat excessively, or to have a chronic alcohol condition – may have resulted in their death.

5.6 The death was due to a person undergoing any treatment or procedure of a medical or similar nature

This applies if the death may be related to surgical, diagnostic or therapeutic procedures and investigations, anaesthetics, nursing or any other kind of medical care. It includes scenarios such as:

- Death that occurs unexpectedly given the clinical condition of the deceased prior to undergoing any procedure.
- Errors made in the medical procedure or treatment e.g. the deceased was given an incorrect dosage of a drug.

- The medical procedure or treatment may have either caused or contributed to death (as opposed to the injury/disease for which the deceased was being treated).
- Death follows from a recognised complication of a procedure that has been given for an existing disease or condition.
- The original diagnosis of a disease or condition was delayed or erroneous, leading to either the death or the acceleration of the death.

It should be noted that a death that has occurred following a medical or similar procedure may not necessarily be due to that treatment; the medical practitioner should consider whether there is a relationship. It is only in circumstances where the medical practitioner believes that the death was due to this procedure that the death should be notified.

5.7 The death was due to an injury or disease attributable to any employment held by the person during the person's lifetime

This includes injuries sustained in the course of employment (including self-employment, unpaid work, work experience or contracted services), for example if the death was due to a fall from scaffolding, or being crushed in machinery. It also includes deaths that may be due to diseases received in the course of employment even if the employment has long ceased. Diseases in the course of employment may include, for example:

- A current or former coal miner who died of pneumoconiosis.
- A current or former furniture worker who died of cancer of the nasal sinuses.
- A current or former construction worker who died of asbestos-related lung disease e.g. asbestosis or mesothelioma.
- A current or former rubber or paint worker who died of bladder cancer

5.8 The person's death was unnatural but does not fall within any of the above circumstances

A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is implicated. For example, this category includes scenarios in which the deceased may have contracted a disease (e.g. mesothelioma) as a result of washing his/her partner's overalls which were covered in asbestos however long before the death occurred.

5.9 The cause of death is unknown

If the attending medical practitioner is unable to determine the cause of death to the best of their knowledge and belief, based upon a conscientious appraisal of the known facts, including after suitable consultation with the Consultant responsible for the patients care and the Medical Examiner, HM Coroner must be notified.

5.10 **The registered medical practitioner suspects that the person died while in custody or otherwise in state detention**

This is relevant where the person was compulsorily detained by a public authority regardless of the cause of the death. This applies whether the custody or state detention was in England and Wales or elsewhere and includes:

- Hospitals, where the deceased was detained under mental health legislation (including instances when the deceased is on a period of formal leave).
- Prisons (including privately run prisons).
- Young Offender Institutions.
- Secure accommodation for young offenders.
- Secure accommodation under section 25 of the Children Act 1989
- Any form of police custody e.g. the deceased was under arrest (anywhere) or detained in police cells.
- Immigration detention centres.
- Court cells.
- Cells at a tribunal hearing centre.
- Military detention.
- Bail hostel.
- When the deceased was a detainee who was being transported between two institutions.
- Any death in which the person would ordinarily have been in state detention but had been temporarily released (for example for medical treatment) or had absconded from detention.

This **does not** include circumstances where the death occurred while the deceased was subject to a Deprivation of Liberty Order unless the person was additionally subject to custody or detention as described above.

5.11 **The death was a result of a complication with either mother or baby during childbirth which could result in a death that could be deemed unnatural**

E.g. asphyxiation of the baby.

5.12 **All medical termination cases whereby there has been signs of life after the birth for any period of time, must be reported to HM Coroner whatever the gestation**

5.13 **Sepsis of unknown aetiology**

Acceptable as 1a, however not as 1b, i.e. leading to another condition. In those circumstances sepsis of unknown aetiology must be qualified by 1c, or referred to HM Coroner.

5.14 **Heart Failure**

Although an acceptable cause of death on the Royal College of Pathologists Cause of Death List 2020, HM Coroner for Somerset requests this is not used as a cause on its own. If this is to be used as a sole cause of death it must be referred. However if supported by another acceptable condition in 1b, referral is not necessary.

5.15 The identity of the deceased person is unknown

- If the identity of the deceased is not known, then it follows that the deceased's medical history is unknown, precluding the completion of an MCCD. In this scenario the death must be notified to HM Coroner.
- Where the identity of the deceased is unknown it is recommended that the death is also reported to the police.

6.0 NOTIFICATION TO HM CORONER

6.1 Who can make the Notification?

- A registered medical practitioner means a person on the General Medical Council's list of Registered Medical Practitioners, who has a licence to practice.
- It is anticipated that where available, it will be one of the attending medical practitioners who is qualified to complete the MCCD, who will be making the notification to HM Coroner. Otherwise it is acceptable that another senior medical practitioner, or the Medical Examiner, can make the referral in exceptional circumstances. In some instances, the patient may only have seen an Advanced Clinical Practitioner (ACP), who is not registered with the General Medical Council. In this circumstance the referral can **only** be made by the ACP if they have discussed it with a Consultant **and** the Medical Examiner and they state, within the referral, who they have discussed with.
- A death may have already been reported to HM Coroner by a person other than a medical practitioner, such as a friend or family member of the deceased, or the police. Such reports may not provide HM Coroner with the full medical picture. Therefore, even if a medical practitioner is aware that someone other than a medical practitioner has reported a death to HM Coroner, the registered medical practitioner should still make a notification under the Regulations.

6.2 Written Notification

- Notification to HM Coroner should be in the form of an Electronic Death Reporting Form, which is completed and emailed to HM Coroners Officers. It can be found on the Trust Intranet Bereavement Services page or contact the Bereavement & Medical Examiner Office and they can email a version to you. Medical practitioners must ensure that **all** fields are completed fully with the details requested.
- It is expected that medical practitioners and Bereavement & Medical Examiner Office will

operate with IT systems which will facilitate the electronic transfer of information and records to HM Coroner, which includes the scanning of paper records and documents or the creation and transfer of electronically stored records and documents.

6.3 Verbal Notifications

- Notification can be provided by telephone in exceptional circumstances. There may be circumstances or occasions where the IT infrastructure or systems required to facilitate the transfer of information, records and documents is not available for a timely written notification to be made to HM Coroner. Where the notifying medical practitioner does not have access to the facilities required to make a notification in written form you should inform HM Coroner of the reasons for this when making verbal notification.
- Following a verbal notification, the notifying medical practitioner must, as soon as is reasonably practicable provide a written notification, confirming the information given in the verbal notification.

6.4 Information to be provided to HM Coroner

- Notification to HM Coroner should be made as soon as is reasonably practicable after the medical practitioner has determined that the death should be notified. This will usually be via the local Coroner's Office. While the regulations do not prescribe a specific time limit, this notification should be prioritised. If the death arises from an event or occurrence that may be suspicious then the police should be informed immediately.
- The medical practitioner should usually take reasonable steps to establish the cause of death before notifying HM Coroner. This is done by discussing with the Consultant responsible for the person's care, followed by a discussion with the Medical Examiner. However, where the death is clearly unnatural it may be more appropriate for a notification to be made to HM Coroner straight away.
- The medical practitioner must provide the full details of the person who has died, including their full date of birth, address and General Practitioner details, and the date and time the death was verified. A patient's death should be verified within **1 hour** in an Acute Hospital and within **4 hours** in a Community setting, as per Hospice UK Guidance on Care After Death (2015).
- The medical practitioner should provide to HM Coroner the name of the Person in Hierarchy of Qualifying Relationships or, where there is none, the person responsible for the body of the deceased. Where there is no identifiable person who may be responsible for the body, the Bereavement & Medical Examiner Office will liaise with HM Coroner's Officers regards which local authority will be taking responsibility.
- The notifying medical practitioner will provide a detailed explanation of the likely cause of death in narrative form. Where possible, this should include the proposed medical cause of death and an explanation of any technical terms used. Abbreviations **must not** be used

in the narrative or in the cause of death as, in Somerset, HM Coroner and his Officers are not medical practitioners.

- The medical practitioner must provide any further information that they consider to be relevant to HM Coroner. This provision allows for circumstances where a Coroner requests medical practitioners to include information relevant to their investigation that is additional to that specifically listed within the Regulations.
- A Coroner's investigation may not be necessary in all notifiable cases. If HM Coroner is satisfied that they do not need to carry out any investigations then they may issue a Part A 100 form and refer the case back to the medical practitioner and Bereavement & Medical Examiner Office, who can arrange for the issuing of the MCCD.

7.0 ARRANGEMENTS FOR CORONER'S POST-MORTEM

If HM Coroner decides that a post-mortem is necessary to ascertain the cause of death, or investigate the circumstances of an unnatural death by way of Inquest, they take over the patient's case entirely. The Consultant in charge of care might be requested to give details but the clinical team have no responsibility for arranging the examination in this circumstance. If you have any doubt at all about referral to HM Coroner, do not hesitate to discuss it with either the Medical Examiner or the HM Coroner's Officer.

8.0 REQUIREMENTS FOR CERTIFICATION OF DEATH

Legal status - The Death Certificate is a statutory document; it is a requirement for all deaths (Births & Deaths Registration Act - 1953).

- If there is an attending medical practitioner who is responsible for signing the MCCD they must have seen the patient alive within the last 28 days (including visual/video consultation).
- In hospitals there may be several medical practitioners in a team caring for the patient. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified.
- If there is no attending medical practitioner available, then any medical practitioner with GMC registration can sign the MCCD and complete the cremation form Part 4, even if they did not attend the deceased during their last illness. Please see section 12.0 for the process in these circumstances.
- It is ultimately at the discretion of a medical practitioner to determine what would be a 'reasonable time' based on the individual circumstances of the case. However, it is recommended that where there is an attending medical practitioner, they should complete an MCCD as soon as possible.
- It should be noted that a death must legally be registered within 5 days from the date of

death, and that the MCCD is needed for such a registration to be made within this time limit. Therefore, the completion of the MCCD **must not** exceed this time limit, unless there has been Coronial involvement, in which case the 5 day limit is waived.

9.0 THE CAUSE OF DEATH AND HOW TO COMPLETE A MCCD - SEE APPENDIX B

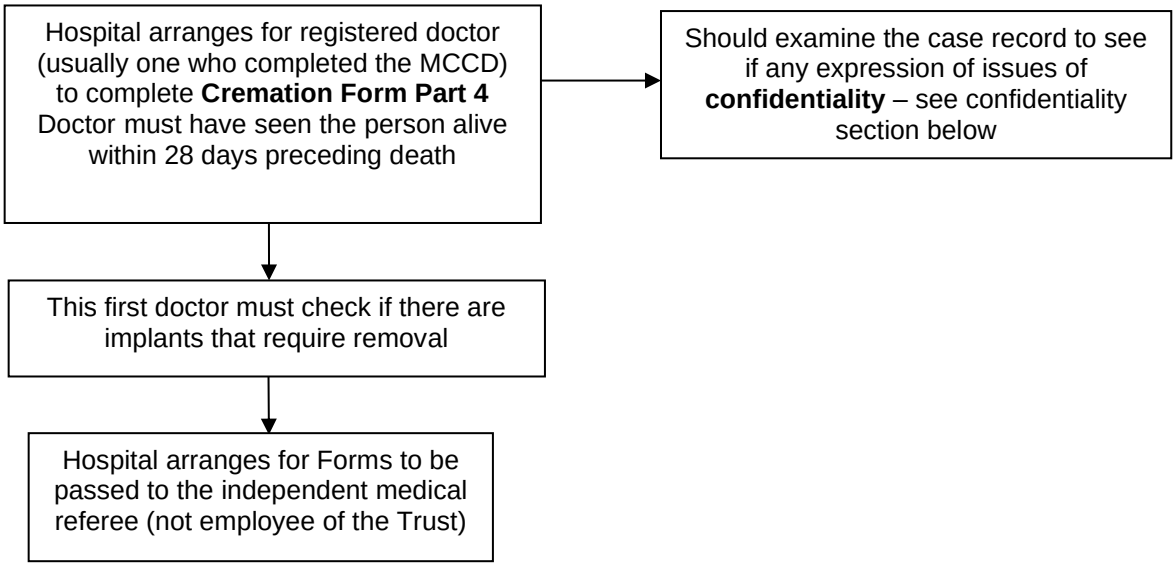
10.0 REQUIREMENTS FOR CREMATION

Certification for Cremation is a process defined in Law (Cremation Act 1902) which prevents the destruction of human remains before exclusion of criminal activity and without the permission of relatives. It also concerns safety issues including the safe disposal of cardiac pacemakers and implanted cardiac defibrillators, radioactive devices, and fixation intramedullary nailing systems. In general there are two stages involving doctors. **First** a declaration by a registered doctor (provisionally or fully) as to the causes of death (usually the doctor who signed the MCCD - Cremation Part 4). **Secondly** Part 4 is then scrutinised by a senior Medical Practitioner (known as the Medical Referee) external to the Trust. Medical referees have the statutory power to reject incomplete forms and may refuse to authorise cremation until the forms are completed to their satisfaction. Medical referees also have the power to make any enquiry they may consider necessary about an application or certificate.

The doctor must not be a relative or friend of the deceased.

Cremation documentation should be completed as soon as possible. It should be done the same day, or the following working day if the death occurred out of hours, to limit delays and distress for relatives

11.0 Scheme of certification for cremation – (for deceased person not referred to HM Coroner or subject of a non-coronial PM) – see text table



When there is a non-coronial post-mortem, only form Cremation 4 needs to be completed (by the consultant pathologist who performed the post-mortem provided they are not a relative of the deceased).

The Cremation form requests to know the occupation of the person, even if they are retired. To fulfil this, it is essential that occupation is recorded by the medical staff for all patients admitted and including main previous occupation if retired. It is also important to provide the name and Trust address for the person present at the death.

Confidentiality - The applicant for cremation has a legal right to inspect forms Cremation 4. Some of the information which is requested by the forms (in particular, questions 9 and 12 on form Cremation 4) might have been given by the deceased in confidence. If confidential information were included in the form, it may be disclosed to the applicant for cremation if they chose to inspect the form. If the deceased person had given information with a directive for confidentiality after his/her death and this were disclosed, this would be a breach of confidence. Doctors should examine the notes for evidence of any directives, and if one is found, the doctor should give the information to the medical referee on a separate headed sheet of paper attached to the form explaining the reasons for this and that the information should not be disclosed. It is therefore important that this is borne in mind when the forms are completed. To maintain confidentiality in general terms, the forms are placed in a sealed envelope before being handed to the funeral director. Any information required by the funeral director that does not breach confidentiality is written on the envelope.

12.0 PROCESS FOR THE CERTIFICATION OF DEATH BY NON-ATTENDING MEDICAL PRACTITIONER

A medical practitioner who has not seen the person alive within 28 days preceding their death, can only sign the necessary paperwork, if the following conditions are met:

- The medical practitioner who proposes to sign the MCCD can state the cause of death to the best of their knowledge and belief and,
- They have attended the deceased during their final illness (including visual/video consultation) and,
- They have viewed the person after death and,
- They have had permission from HM Coroner to do so.

13.0 PROCESS OF REGISTRATION

The purpose of the Death Certification process is to provide the Person in Hierarchy of Qualifying Relationships (PHQR) with information about the reason for the death, and information that might be relevant to their own healthcare. A certified copy of the Death Certificate allows the PHQR to make arrangements for a funeral and to settle the deceased person's estate. The information on the Death Certificate also provides an important source of statistical information for national government.

The completed MCCD is scanned and sent to Somerset Registrations via email by the Bereavement & Medical Examiner Office. The PHQR will then need to contact Somerset Registrations to arrange the registration of death. When the registration of death is completed by the Registrar (of Births Deaths and Marriages) & the PHQR, the Registrar then issues a certified copy of the MCCD, known as the 'Death Certificate'. The Registrar will also issue a Certificate for Burial or Cremation (called the 'green form'), giving permission for the deceased person to be buried or for an application for cremation to be made.

14.0 CHILD DEATH REVIEW PANEL

Any death of a person under the age of 18 must be referred to the Child Death Review Panel. See the Joint Agency Review of all Unexpected Deaths in Childhood policy.

15.0 NOTIFICATION OF IN-PATIENT DEATH

(On the EPRO discharge summary electronic record) This is completed for every in-patient death the same day as the death or the following working day if out of hours. (If the doctor is unavailable to complete it in this timeframe the Bereavement & Medical Examiner Officer will notify the GP by phone).

16.0 RELEASE OF THE DECEASED PERSON OUT OF HOURS

This is only possible in exceptional circumstances. For advice Out of Hours contact the Clinical Site team who can discuss with the 'on call' Anatomical Pathology Technician.

17.0 NOTIFIABLE DISEASES

Some infectious diseases are classified as 'notifiable', and it is a legal requirement that these cases are reported to PHE local Health Protection Team. To report cases to the Devon, Cornwall and Somerset PHE Centre telephone 0300 3038162. To report urgent cases out of hours, contact switchboard and ask for Health Protection first on call. It is the responsibility of the relevant medical team to report each case**.**

See Appendix A

18.0 REQUIREMENTS FOR CERTIFICATION OF STILLBIRTH

Definition - A stillbirth is defined as a child born with **no** signs of life after the end of the 24th week of pregnancy.

Legal status - The current law on stillbirth registration is set out in the Births & Deaths Registration Act 1953 (amended by the Stillbirth (Definition) Act 1992). Coroners do not normally have jurisdiction over stillbirth but they have discretion to be involved if the death followed a criminal act such as common assault.

Uncertain dates - When the gestational age was not known before the birth, with un-booked pregnancies for example, the decision about the status of the birth should be made on the basis of the stage of development of the baby on examination.

Suspected criminal action – If it is suspected that deliberate attempts were made to procure a stillbirth the police should be contacted.

No healthcare worker at birth – If no member of the healthcare team attended the birth, and it is a fresh stillbirth, HM Coroner should be contacted.

Special status for earlier foetal death - Legal advisors for the Department of Health and the Office for National Statistics have agreed that a foetus that is delivered after 24 weeks of pregnancy, provided it was no longer alive at the end of the 24th week of pregnancy (this fact being either known or provable from the stage of development reached by the dead foetus), does not fall within the category of births to be registered as stillbirths under the above Acts.

Process of certification - The doctor or midwife attending the stillbirth is required to issue a Medical Certificate of Stillbirth that enables the birth to be registered. (If a doctor or midwife did not attend the birth, HM Coroner should be contacted for guidance).

The cause and sequence of medical events leading to the intra-uterine foetal death (IUFD) should be given in as much detail as possible. Non-specific terms such as anoxia, prematurity etc should be avoided. Certification should not be delayed for the results of post-mortem. The cause of death need not be known for the certificate to be completed and issued.

Registering the stillbirth - The mother (or father if the couple were married at the time of birth) is responsible for registering the stillbirth normally within 42 days but with a final limit of three months for exceptional circumstances. This responsibility can be delegated to health professionals, including midwives. The person registering the birth must be able to provide the following:

- The place and date of birth of the baby
- If the parents wish to name the baby the name and surname
- The sex of the baby (can be registered as indeterminate sex & later changed)
- The names, surnames, places of birth and occupations of the parents
- The mother's maiden name (if applicable)

The Registrar of Births will meet with the parents in private. The birth is entered on to the Stillbirth Register, which is separate from the standard Register of Births. The mother is then issued with a Certificate of Stillbirth and the documentation (called the 'white form') to apply for burial or cremation.

Cremation - A certificate for cremation cannot be issued before the registration of the stillbirth.

Status of father - If the couple were not married, the father's details can only be added if one of the following is fulfilled:

- The mother and father go to the register office and sign the stillbirth register together **or**
- Where the father is unable to go to the register office with the mother - the father may make a statutory declaration acknowledging his paternity which the mother must produce to the registrar (this form may be obtained from any registrar of births) **or**
- Where the mother is unable to go to the register office with the father - the mother must make a statutory declaration acknowledging the father's paternity which the father must produce to the registrar (this form may be obtained from any registrar in England or Wales).

If information about the father is not recorded initially, it might be possible for the stillbirth to be re-registered to include his details at a later date.

Fees - There are no fees for registering a stillbirth, but additional certificates do carry a charge.

19.0 REQUIREMENTS FOR HOSPITAL (NON-CORONIAL) ADULT PM EXAMINATION

Background - Post-mortems are mostly requested by HM Coroner to ascertain the cause of death or investigate unnatural deaths. Occasionally the cause of death is known and natural, a MCCD can be issued, but a post-mortem is requested by a medical practitioner for purposes of research, education, or additional information for relatives. For further information on how to arrange a Hospital Post -Mortem, please see the Trust Consent for post-mortem examination, blood sampling, retention and disposal of tissues SOP.

20.0 OTHER POLICIES LINKED TO THIS POLICY

- Care After Death policy
- Joint Agency Review of all Unexpected Deaths in Childhood policy
- Organ and Tissue Donation policy
- Health Care Associated Infection (HCAI) Investigation, Surveillance and Reporting Policy
- Verification of expected death of adult patients by registered nurses and AHP's
- Consent for post-mortem examination, blood sampling, retention and disposal of tissues

21.0 TRAINING/COMPETENCE REQUIREMENTS

21.1 GMC registered medical practitioner

21.2 F1 Induction and Foundation Training, provided by the Lead Bereavement & Medical Examiner's Officer

21.3 Doctors are given 1:1 support by the Bereavement Team

21.4 NMC registered Midwife

22.0 MONITORING

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency / reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
Completion of MCCD/cremation papers accurately	**15 & 18**	Each document checked by Bereavement & Medical Examiner Officers. Ensuring each section is completed accurately, with no abbreviations and is signed, name printed & GMC number present	Lead Bereavement & Medical Examiner Officer	Continuous / reporting to be done annually & presented to Clinical Support & Specialist Services Governance Group	Feedback can be given at the time of completion and by the Registrars of Births Deaths & Marriages who review every MCCD for accuracy. Overseen by Clinical Support & Specialist Services Governance Group
Notification to HM Coroner	**5, 6, 7, 8 & 9**	Ensuring a patient is referred to HM Coroner appropriately as per Ministry of Justice Guidance and Notifications of Deaths Regulations.	Lead Bereavement & Medical Examiner Officer	Continuous / reporting to be done annually & presented to Clinical Support & Specialist Services Governance Group	Feedback can be given at the time of completion of EDRF and by HM Coroner or his Officers. Overseen by Clinical Support & Specialist Services Governance Group
Completion of Medical Certificate of Stillbirth	**14**	Each case is checked by the Lead Bereavement Midwife to ensure they have been completed correctly.	Lead Bereavement Midwife	Continuous / reporting to be done annually & presented to Families & Paediatric Care Governance Group	Feedback provided by the Lead Bereavement Midwife. Overseen by Families & Paediatric Care Governance Group

23.0 REFERENCES

23.1 Cremation Regulations Ministry of Justice (2008) Cremation Act 1902

23.2 Intrauterine death Royal College of Obstetricians and Gynaecologists (1010)

23.3 Code of Practice (2008) of the Death Certification Advisory Group, Office of National Statistics, and Ministry of Justice.

23.4 Births and Deaths Registration Act of 1953

23.5 The Notification of Deaths Regulations 2019

23.6 Ministry of Justice Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019

23.7 Care After Death – Guidance for staff responsible for care after death. Hospice UK 2015

23.8 Coronavirus Act – excess death provisions: information and guidance for medical practitioners NHS England & NHS Improvement 2020

23.9 Cause of Death List, Royal College of Pathologists 2020

24.0 APPENDIX A – Diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010:

Acute encephalitis

Acute infectious hepatitis

Acute meningitis

Acute poliomyelitis

Anthrax

Botulism

Brucellosis

Cholera

Covid-19

Diphtheria

Enteric fever (typhoid or paratyphoid fever)

Food poisoning

Legionnaires' disease

Leprosy

Malaria

Measles

Meningococcal septicaemia

Mumps

Plague

Rabies

Rubella

Severe Acute Respiratory Syndrome (SARS)

Scarlet fever

Smallpox

Tetanus

Tuberculosis

Typhus

Viral hemorrhagic fever (VHF)

Whooping cough

Yellow fever

25.0 APPENDIX B

The cause of death and how to complete on a MCCD

The prime aim of Certification is to accurately document the cause of death, if it is known, with as much precision as possible. This provides information to relatives, partly to understand the reason behind the death, but also to provide information for their own healthcare. The information is also used for national statistics.

The most precise information available should be provided. This includes detail of anatomical locations, particular infections types (including antibiotic resistance) etc.

The main cause - is entered in '**1'** of the certificate. This has three parts (a, b and c), intended to denote a logical sequence of events leading to the death. Thus, 1a must be due to 1b which in turn is due to 1c, for example:

1a	Intraperitoneal haemorrhage
1b	Ruptured liver metastasis
1c	Primary carcinoma of ascending colon

Enter in '**II'** other diseases, not related to the cause given in '**1**', but which are nevertheless relevant to the cause of death. Do not enter conditions which are not relevant to the death.

Organ failure – Use of terms such as renal failure, liver failure etc. and septicaemia are not acceptable alone as a cause. These terms must be qualified with the underlying pathological disease process, e.g.:

1a Respiratory failure 1b Chronic obstructive pulmonary disease

or

1a Septicaemia, 1b Acute pyelonephritis

Mode of dying – Descriptions such as syncope, cardiac arrest, collapse should not be used.

Dual pathology – In circumstances in which two diseases are present but it is unclear which played the greater role, both can be included on one line –

1a	Hepatic failure
1b	Liver cirrhosis
1c	Hepatitis C infection & chronic alcoholism (jointly)

Uncertain anatomy - In some instances, the disease process may be clear, but the precise anatomical location of the underlying pathology is unknown e.g. carcinomatosis (unknown primary) or perforated abdominal viscous. These terms are acceptable for death certification.

Outstanding investigations – If the cause of death is accurately known in broad terms, the death certificate can be issued while further investigations are awaited. Examples might include meningitis in which the organism is not known and disseminated cancer, but the tissue type is not known. The doctor can circle 2 in the front sheet if a non-coroner's post-mortem is to be performed, and by ticking box B on the back if the results of ante-mortem investigations will become available.

Use of non-specific terminology – Whenever possible a specific cause of death should be given. In general, the term *old age* as a cause of death should be avoided whenever possible. It is sometimes used but should only be employed in a very restricted way. It can only be used when the person is over 80 years. The term *natural causes* must never be used.

Abbreviations and medical symbols - Abbreviations must not be used - COPD, IHD, HIV etc. The certificate will be rejected by the Registrar of Births & Deaths if there are any abbreviations.