Death Certification – issuing eMCCD using NIECR*

INDEX

BEFORE

you proceed with completing a Medical Certificate of Cause of Death (MCCD), ask yourself this question,

"Should this Death be reported to the Coroner?"

* = Northern Ireland Electronic Care Record (NIECR)

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Bookmarks

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For Internet Explorer: right click, select 'Show the Navigation Pane', click the icon on the left hand of the screen.

For Chrome: click the icon on the toolbar at the top-left of the screen.

For Microsoft Edge: (which is a new browser included as part of Windows 10), this browser does not currently support the use of bookmarks. Please use Internet Explorer.

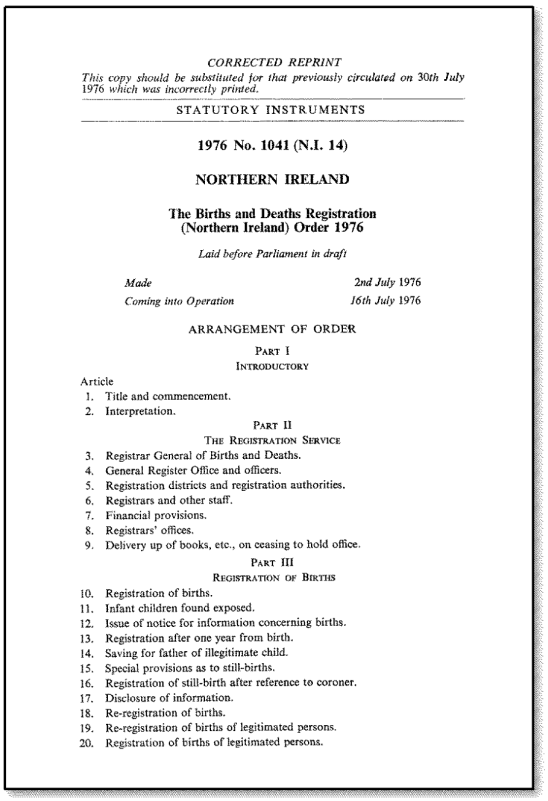
INTRODUCTION

When someone dies, the death must be registered by the General Register Office for Northern Ireland (GRO). Before it can be registered, the Registrar must be provided with notification of the death and either a Medical Certificate of the Cause of Death (MCCD) from a doctor or authorisation from a Coroner. For most deaths, the doctor who attended and provided care within twenty-eight days of death completes the MCCD to the best of their knowledge and belief; a statutory requirement. This is delivered to the local Registrar who issues the formal Death Certificate and an authority for the disposal of the body (Form GRO21).

The purposes of Death Certification

Death Certification serves social, legal and health functions. It,

- allows completion of a permanent legal record of the fact of death in the form of the Death Certificate;
- enables the family to make funeral arrangements; and
- the Registrar can provide copies of the Death Certificate, enabling the family to settle the deceased's estate.



CORRECTED REPRINT

This copy should be substituted for that previously circulated on 30th July 1976 which was incorrectly printed.

STATUTORY INSTRUMENTS

1976 No. 1041 (N.I. 14)

NORTHERN IRELAND

The Births and Deaths Registration (Northern Ireland) Order 1976

Laid before Parliament in draft

Made — *2nd July* 1976

Coming into Operation — *16th July* 1976

ARRANGEMENT OF ORDER

PART I
INTRODUCTORY

Article
1. Title and commencement.
2. Interpretation.

PART II
THE REGISTRATION SERVICE

3. Registrar General of Births and Deaths.
4. General Register Office and officers.
5. Registration districts and registration authorities.
6. Registrars and other staff.
7. Financial provisions.
8. Registrars' offices.
9. Delivery up of books, etc., on ceasing to hold office.

PART III
REGISTRATION OF BIRTHS

10. Registration of births.
11. Infant children found exposed.
12. Issue of notice for information concerning births.
13. Registration after one year from birth.
14. Saving for father of illegitimate child.
15. Special provisions as to still-births.
16. Registration of still-birth after reference to coroner.
17. Disclosure of information.
18. Re-registration of births.
19. Re-registration of births of legitimated persons.
20. Registration of births of legitimated persons.

This provides the family with an explanation of how and why their relative died. It also gives them a permanent record of information about their family medical history, which may be important for their own health and that of future generations.

In addition, the MCCD, provides the **underlying cause of death which** influences,

- population health monitoring;
- design and evaluation of public health interventions;
- recognition of priorities for medical research and health services;
- planning of health services; and
- assessment of the effectiveness of services.

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WHO CAN COMPLETE THE MEDICAL CERTIFICATE OF CAUSE OF DEATH?

Doctors certifying deaths do so as a *statutory* duty under the Births and Deaths Registration (Northern Ireland) Order 1976 Section 25(2) which holds that,

> *"Where any person dies as a result of any natural illness for which he has been treated by a registered medical practitioner within twenty-eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified informant a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death, together with such other particulars as may be prescribed."*

MCCDs can only be completed by a registered medical practitioner who saw and treated the deceased during their last illness. No other person or practitioner may sign the certificate on his/her behalf. The completion of MCCDs is a statutory duty with doctors being subject to regulation of their conduct by the General Medical Council, rather than a condition of employment in the NHS. They **must** state the cause(s) of death to the best of their knowledge and belief and give the certificate forthwith[1] to the Informant or report to the Coroner if necessary.

The General Medical Council guidance Treatment and care towards the end of life: July 2010, provides a framework for good practice when providing treatment and care for patients who are reaching the end of their lives. Section 85 states, *"You must be professional and compassionate when confirming and pronouncing death and must follow the law, and statutory codes of practice, governing completion of death and cremation certificates. If it is your responsibility to sign a death or cremation certificate, you should do so without unnecessary delay. If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient's wishes if they are known."*

In hospital, there may be several doctors in a team caring for the patient who will be able to certify the cause of death. It is ultimately the responsibility of the Consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete MCCDs unless they have received appropriate training. Discussion of a case with a senior colleague may help clarify issues about completion of an MCCD or referral to a Coroner.

In general practice, more than one GP may have been involved in the patient's care and so be able to certify the cause of death.

A doctor, who had not been directly involved in the patient's care at any time during the illness from which they died, cannot certify the cause of death, but they should provide the Coroner with any information that may help to determine the cause of death.

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[1] Definition of forthwith: In official use, forthwith means immediately; without delay.

The MCCD **must** be completed and signed by the doctor who saw and treated the deceased for their cause of death within 28 days of death.

The MCCD should be completed as soon as possible after death occurs and given to the Informant; the legislation indicates that this must be immediately, without delay, remembering that Registration should occur within 5 days of receiving the MCCD and **before** burial or cremation is performed.

Doctors are expected to state the Cause of Death to the best of their knowledge and belief.

It is good practice to keep a paper copy of the printed eMCCD in the patient clinical records.

All registered medical practitioners completing MCCDs should ensure they are competent by updating their knowledge and regularly reflecting on their practice.

- For further guidance and how to obtain an eMCCD using the NIECR, please view How to complete a Medical Certificate of Cause of Death using NIECR - printed.

Abbreviations or symbols

The only abbreviations a Registrar can accept are,

- HIV for Human Immunodeficiency Virus infection;
- AIDS for Acquired Immune Deficiency Syndrome; and
- MRSA for Methicillin Resistant Staphylococcus Aureus.

Do not use other abbreviations on MCCDs. Their meaning may seem obvious to medical staff in the context of their work and their medical history, but it may not be clear to others and therefore may be a source of ambiguity causing potential delay to the registration process. Inappropriate use of abbreviations can result in the cause of death being recorded incorrectly on Death Certificates.

For example, using,

- MI instead of myocardial infarction. Does,
  - a death from “MI” refer to myocardial infarction or mitral incompetence?
- MS instead of multiple sclerosis. Does,
  - MS refer to multiple sclerosis, mitral stenosis or morphine sulphate?
- (L) instead of left;
- medical symbols such as 1° instead of primary; or
- # instead of fracture.

GMC registered name and reference number

There is GMC guidance on what registered doctors must do regarding the use of their registered name and GMC reference number.

http://www.gmc-uk.org/doctors/information_for_doctors/doctors_registration_number.asp

Registered name

This is your **full name**, as it appears in the Medical Register.

GMC reference number

This is the 7-digit number given when you first register with the GMC. Always use your own GMC number when completing a MCCD.

You must,

- Be familiar with your GMC reference number;
- Use your registered name when signing statutory documents; and
- Make your registered name and GMC reference number available to anyone who asks.

Responsibility to the Family and Informant

Please note that once you have signed and dated the eMCCD, best practice indicates that you should give it to a family member or next of kin, if one of them is available.

There is an expectation that you will explain the details contained within the Cause of Death section to family members of the deceased. See Treatment and care towards the end of life: General Medical Council, July 2010, Section 85.

> *"..... If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient's wishes if they are known."*
>
> Treatment and care towards the end of life: General Medical Council, July 2010

Signing the eMCCD

Once the printed eMCCD is obtained, the doctor **must** sign and date the certificate. The eMCCD **must** be signed by the doctor who logged into NIECR and completed the Initial Record of Death (IRD); the printed doctor's name and their signature must match.

It is not acceptable for an eMCCD to be signed on behalf of someone else i.e. with the signature preceded by p.p. (per procurationem).

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A STEP-BY-STEP GUIDE TO COMPLETING AN eMCCD

Since November 2016, there have been 2 methods of completing and obtaining a Medical Certificate of Cause of Death (MCCD) in Northern Ireland.

1. Using the Northern Ireland Electronic Care Record (NIECR).
   This is now the standard method of recording a death and producing a MCCD in Health and Social Care (HSC) Trust hospitals. The MCCD is completed electronically on the NIECR producing an eMCCD, which then must be printed and signed – a printed eMCCD.

   This guidance refers to using the NIECR to print the eMCCD.

2. Completion of the handwritten MCCD.
   A handwritten MCCD remains the method of recording a death and producing a MCCD in primary care, community hospitals, nursing homes, hospices, in the home and also as a contingency measure when NIECR is non-functioning.

   If guidance is required regarding handwriting the MCCD, click here.

Using NIECR to produce a printed eMCCD

1. The items of information required before you can go through the steps needed to produce the printed eMCCD are provided here (& printed from here).

2. The steps required to produce the printed eMCCD (& printed from here) are,
   - logon to NIECR using a secure user name and password;
   - if you are a Locum and do not already have a secure NIECR user name and password, you should use the contacts listed here.
   - from the NIECR Home screen, access the correct deceased patient's record;
   - from their Patient Summary screen, enrol the deceased onto Mortality Pathway;
   - complete an Initial Record of Death (IRD);
   - return to their Patient Summary screen;
   - access the Notification & Legal documents section; and
   - print the eMCCD and/or Clinical Summary.

3. Detailed instructions to produce and print the eMCCD can be found here including a diagrammatic flowchart explaining the sequence. To print these instructions click here and for printing the flowchart sequence click here.

Further guidance

Further guidance and how to,

- Edit or Amend an eMCCD, which has not yet been Registered with the GRO;
- Correct an eMCCD entry, which has already been Registered with the GRO;
- Deactivate a eMCCD (Rarely performed - only if eMCCD completed in error)

can be accessed in the Regional M&M Review System guidance (available shortly)
or
viewed in How to complete a Medical Certificate of Cause of Death – eMCCD printed.

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Recording the Cause of Death

The Cause of Death details (excluding the interval between onset of condition and death), as certified by a medical practitioner, are entered by the Registrar in the GRO's death register and form part of that record. The entry in the death register and the Death Certificate itself are also utilised as material for the mortality statistics published by the Registrar General. These statistics are used in many fields, particularly in the study of preventative medicine, and their value will be materially enhanced if certifying medical practitioners will,

Underlying Cause of Death

Definition

(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.

World Health Organisation

(a) read and adopt, as far as possible, the suggestions as set out below, remembering that the International Classification of Causes of Death is based, not upon terminal clinical states, but upon ***the antecedent and underlying pathological cause(s) of death***, of which the certifier is generally best qualified to form an opinion.

(b) complete the Cause of Death accurately, as absence of information may cause undue delay and anxiety to bereaved families during the registration process. Doctors are expected to state the Cause of Death to the best of their knowledge and belief.

The Cause of Death section of the MCCD is set out in two parts, in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD) as shown below.

		These particulars not to be entered in Death Register
I **Disease or condition directly leading to death***	CAUSE OF DEATH I (a) ..... IMMEDIATE CAUSE OF DEATH ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) ..... ANTECEDENT CAUSE(S) ..... due to (or as a consequence of)	.....
	(c) .... UNDERLYING CAUSE(S) OF DEATH	.....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	II .....OTHER SIGNIFICANT CONDITIONS	....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Part I - Sequence leading to death and Underlying Cause
This is used to show the immediate cause of death and any underlying cause(s).

Start with the,

- immediate, direct Cause of Death on line I (a); then
- go back through the sequence of events or conditions that led to death on subsequent lines I (b) and I (c); until
- you reach the one leading ultimately to death = **Underlying Cause of Death**.

This should ALL be in Part I.

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. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

Part II - Contributory causes
You should enter any other <u>significant</u> diseases, injuries, conditions, or events that contributed to the death, but were <u>not</u> part of the direct sequence, in Part II of the certificate.

Part II should <u>not</u> contain the Underlying Cause of Death.

For example, someone with diabetes mellitus who died of 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 cancer, it is likely that osteoarthritis would not have significantly contributed to death, so it should not be mentioned in Part II.

Example 1

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)...INTRA-PERITONEAL HAEMORRHAGE	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	due to (or as a consequence of) (b)...RUPTURED METASTATIC DEPOSIT IN LIVER ..... due to (or as a consequence of) (c)...PRIMARY ADENOCARCINOMA OF ASCENDING COLON.....	....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II** ... TYPE 2 DIABETES MELLITUS	....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Single condition causing death

A single disease, without any antecedents, may be wholly responsible for causing death e.g. subarachnoid haemorrhage or meningococcal meningitis. In this case it is perfectly acceptable to complete only one line. In this case, it should be entered on line (a) and the other lines left blank (Examples 2, 3).

Example 2

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)... MENINGOCOCCAL SEPTICAEMIA ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)..... due to (or as a consequence of)	.....
	(c).....	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	.....	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Example 3

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)... LOBAR PNEUMONIA ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)..... due to (or as a consequence of)	.....
	(c)	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	.....	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

More than three conditions in the sequence

The MCCD has 3 lines in Part I for the sequence leading directly to death. If you want to include more than 3 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 (Example 4).

Example 4

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)... POST-TRANSPLANT LYMPHOMA ..... due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... IMMUNOSUPPRESSION FOLLOWING RENAL TRANSPLANT ..... due to (or as a consequence of)	
	(c)... GLOMERULONEPHROSIS DUE TO TYPE 2 DIABETES MELLITUS.	
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II** ... RECURRENT URINARY TRACT INFECTIONS	

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Where two or more causes must be entered it is important, for purposes of correct classification, that the arrangement of causes should accurately represent the certifying practitioner's opinion as to their order of importance and occurrence.

More than one disease 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 underlying cause of death, you should include them all on the same line on the MCCD and indicate that you think they contributed equally by writing "joint causes of death" in brackets (Examples 5, 6).

Example 5

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ... CARDIO RESPIRATORY FAILURE ..... due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	ISCHAEMIC HEART DISEASE AND CHRONIC OBSTRUCTIVE (b) ..... PULMONARY DISEASE (JOINT CAUSES OF DEATH) ... due to (or as a consequence of)	
	(c)	
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II**	

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Example 6

I	CAUSE OF DEATH	These particulars, not to be entered in Death Register
Disease or condition directly leading to death*	I (a)... HEPATIC FAILURE ..... due to (or as a consequence of)	Approximate interval between onset and death (years, months, weeks, days, hours)
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... LIVER CIRRHOSIS ..... due to (or as a consequence of)	
	(c)... CHRONIC HEPATITIS C INFECTION AND ALCOHOLISM ..... (JOINT CAUSES OF DEATH)	
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	II	

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Where more than one condition is given on the lowest used line of part 1, the GRO will use the internationally agreed ICD mortality coding rules 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.

Specific COVID-19 guidance

The World Health Organisation has stated that for the purposes of the International Classification of Diseases (ICD), the official name of the disease is Coronavirus disease (COVID-19). As there are many types of coronavirus, it is recommended not to use “coronavirus” in place of COVID-19. This helps to reduce uncertainty for the classification or coding and to correctly monitor these deaths.

Medical Practitioners complete MCCDs to the best of their knowledge and belief. Where there has been a laboratory confirmed positive COVID-19 test the preferred terminology to be recorded on the MCCD is,

- **COVID-19 (confirmed)**

In the absence of a confirmed COVID-19 diagnosis, the certifying doctor should consider any available evidence and information and apply their clinical judgement as to whether the disease caused, is assumed to have caused, or contributed to the death. If so, it is acceptable to use the following terminology,

- **COVID-19; or**
- **Probable/Suspected COVID-19**

Recording Healthcare Associated Infections (HCAI)

The level of HCAIs remains a matter of concern to clinicians and the public.

The Health Service depends on accurate information gained from MCCDs to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern or monitor changes in deaths associated with certain infections.

Families may be surprised if an infection the patient was being treated for such as MRSA or clostridium difficile is not mentioned on a MCCD; for some families this can be a very distressing experience (Examples 7, 8, 9).

Example 7

I	CAUSE OF DEATH	These particulars, not to be entered in Death Register
Disease or condition directly leading to death*	I (a)... CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS ..... due to (or as a consequence of)	Approximate interval between onset and death (years, months, weeks, days, hours)
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... MULTIPLE ANTIBIOTIC THERAPY ..... due to (or as a consequence of)	.....
	(c)... COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS	.....
II	II	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	... POLYMYALGIA RHEUMATICA	.....
	... OSTEOPOROSIS	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

It is a matter of clinical judgement if a HCAI was,

- the disease directly leading to the death [record at Part I (a)];
- an antecedent cause [record at Part I (b) or I (c)]; or
- a significant condition not directly related to the cause of death [record at Part II].

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

Example 8

I	CAUSE OF DEATH	These particulars not to be entered in Death Register (Approximate interval between onset and death (years, months, weeks, days, hours))
Disease or condition directly leading to death*	**I**	
	(a)... BRONCHOPNEUMONIA (HOSPITAL ACQUIRED MRSA) ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... MULTIPLE MYELOMA ..... due to (or as a consequence of)	.....
	(c)	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	... CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Example 9

I	CAUSE OF DEATH	These particulars not to be entered in Death Register (Approximate interval between onset and death (years, months, weeks, days, hours))
Disease or condition directly leading to death*	**I**	
	(a)... CARCINOMATOSIS AND RENAL FAILURE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... ADENOCARCINOMA OF THE PROSTATE ..... due to (or as a consequence of)	.....
	(c).....	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	... CHRONIC OBSTRUCTIVE AIRWAYS DISEASE	.....
	... CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Community Acquired and Hospital Acquired Infections

It is important to identify, if possible, the source of a HCAI as either Community Acquired or Hospital Acquired. This will allow Trusts to identify learning to inform and underpin continuous improvement.

Therefore, it is incumbent on clinical staff, when completing a MCCD for patients who require the entry of an infection, for example COVID-19, into either Part I or II, that they qualify the entry with where the infection originated – from the Community, the Hospital environment (probable or definite) or as Indeterminate. (Example 10).

Clinicians should use the following table as the basis for judging whether an infection is Community or Hospital based. Within the crossover period of 2 - 6 days it may be difficult to determine exactly where the infection originated; the term 'indeterminate' may be used. However, where there is clear evidence regarding the origin of the infection e.g. known household contact in the community, clinicians may use their clinical judgement in designating the source of infection.

First positive COVID-19 test after admission to hospital in,		**Defined as**	
0 – 1 days	→	**Community**	
2 – 6 days	→	**Indeterminate Source***	
7 - 13 days	→	**Hospital**	(Probable)
14 or more days	→	**Hospital**	(Definite)

* if Clinician has clear evidence of the origin of the infection e.g. known household contact in community, they can designate whether Community or Hospital Acquired.

Example 10

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)... RESPIRATORY FAILURE..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... confirmed COVID-19 PNEUMONITIS – Hospital Acquired ... .(definite) ..... due to (or as a consequence of)	.....
	(c).....	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	... CHRONIC OBSTRUCTIVE AIRWAYS DISEASE	....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

If a patient has died from what is clinically considered to be a COVID-19 infection but there has been no confirmatory testing carried out, the MCCD can be completed as in example 11. The COVID-19 infection should be qualified using the term *probable* or *suspected*.

The clinician may also be able to use their clinical knowledge of the patient to qualify the death as being community or hospital acquired if the length of admission allows that decision to be clearly made.

Example 11

I	CAUSE OF DEATH	These particulars not to be entered in Death Register. Approximate interval between onset and death (years, months, weeks, days, hours)
Disease or condition directly leading to death*	**I** (a)... RESPIRATORY FAILURE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... Community Acquired, probable COVID-19 PNEUMONITIS .... due to (or as a consequence of) ..... (c).....	....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II** ... CHRONIC OBSTRUCTIVE AIRWAYS DISEASE	....

Coroner's cases

Any Cause of Death term on the MCCD which might indicate an industrial disease, trauma, unnatural death or where the wider circumstances may require investigation, might need reporting to the Coroner.

Also, the Extra-statutory list of diagnoses contains terms that may need referred to the Coroner and a Registrar may consider it necessary to refer a case to the Coroner if one of these terms is used.

General principles

1. The statement of the cause of death should be as **specific** as your information allows and to the best of your knowledge and belief.

2. Tentative terms and expressions such as, "likely", "presumably", "probably" or "possibly" are permissible when there is not absolute certainty. They are of better use than no diagnosis at all

3. Pay attention to providing sufficient anatomical detail e.g. aneurysm – indicate whether aortic, other artery, venous, organ affected.

4. Pay attention to providing sufficient pathological detail, for example,
   - indicate underlying disease, if cause of death due to tuberculosis, syphilis or other widely disseminated systemic disease; and
   - try to provide an underlying cause or disease when using certain terms e.g. congestion, embolism, haemoptysis, inflammation, obstruction, oedema, perforation, syncope are used.

5. The use of vague and ill-defined terms is particularly to be avoided. Incorrectly completed forms can cause difficulties for the doctor, Registrar, family, carers and relatives.

6. Do not use abbreviations (except HIV, AIDS and MRSA) or symbols on MCCDs.

7. If a Cause of Death is believed to have had a congenital origin, state this.

8. Do not use the following terms alone and without further additional qualifications or detail,
   - Organ Failure;
   - Cancer;
   - Pneumonia;
   - Infection, sepsis;
   - Malnutrition, Cachexia, Inanition; and
   - Old Age, General Debility of Age, Frailty, Senility and Weakness

Organ failure

Do not certify deaths as due to the failure of any organ or "multi-organ failure", without identifying the organ(s) and specifying the disease or condition that led to the organ failure. Examples which need further information are Liver Failure, Renal Failure and Heart Failure (Example 12).

Example 12

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a)... RENAL FAILURE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)... NECROTISING-PROLIFERATIVE NEPHROPATHY ..... due to (or as a consequence of)	.....
	(c).... SYSTEMIC LUPUS ERYTHEMATOSUS	.....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II** .... RAYNAUD'S PHENOMENON AND VASCULITIS	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Cancer

The terms cancer, neoplasm or tumour should be qualified with the detail of the,

a. histological type;
b. whether malignant or benign;
c. whether primary or secondary (any metastatic spread);
    i. anatomical site of primary occurrence, if known;
    ii. anatomical site of secondary occurrence, if known; and
    iii. if secondary, the site of the primary and date of removal if known;

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 (Example 13).

Example 13

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ..... INTRAPERITONEAL HAEMORRHAGE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... METASTASES IN LIVER ..... due to (or as a consequence of)	.....
	(c) .... from PRIMARY ADENOCARCINOMA OF ASCENDING COLON	.....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II** TYPE 2 DIABETES MELLITUS	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

If there are two sites that are independent primary malignant neoplasms, make that clear (Example 14).

Example 14

I	CAUSE OF DEATH	These particulars not to be entered in Death Register Approximate interval between onset and death (years, months, weeks, days, hours)
Disease or condition directly leading to death*	**I** (a) ..... MASSIVE HAEMOPTYSIS ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... PRIMARY SMALL CELL CARCINOMA OF LEFT MAIN BRONCHUS due to (or as a consequence of)	.....
	(c)	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	..... PRIMARY ADENOCARCINOMA OF PROSTATE	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

If a patient has widespread metastases, but the primary site could not be determined, you should state this clearly (Example 15).

Example 15

I	CAUSE OF DEATH	These particulars not to be entered in Death Register Approximate interval between onset and death (years, months, weeks, days, hours)
Disease or condition directly leading to death*	**I** (a) ..... MULTIPLE ORGAN FAILURE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... POORLY DIFFERENTIATED METASTASES THROUGHOUT ABDOMINAL CAVITY due to (or as a consequence of)	.....
	(c) .... UNKNOWN PRIMARY SITE	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	.....	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Pneumonia

Bronchopneumonia, chest signs and symptoms are common terminal findings but they do not always point to significant infection being the underlying cause or contributor to death. Bronchopneumonia should not be written as the sole cause of death, if there is another condition which you can also state as the underlying cause of death.

However, if pneumonia is a cause of death, the following details should be provided, if known,

- Type or site of pneumonia (lobar, bronchopneumonia);
- Organism;
- Whether hospital or community acquired; and

- Sequence of conditions leading to pneumonia, including any relationship to aspiration or the use of mechanical ventilation.

Remember to include, in the sequence in Part I, any predisposing conditions, especially those that may have led to paralysis, immobility, difficulty swallowing, depressed immunity or wasting, as well as any chronic respiratory conditions such as chronic bronchitis (Example 16).

Example 16

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ..... BRONCHOPNEUMONIA ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... IMMOBILITY AND WASTING ..... due to (or as a consequence of) (c) .... ALZHEIMER'S DISEASE	....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II**	....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Infections, sepsis

Where possible give details about:

- Site (meningitis, peritonitis, wound site, etc);
- Organism;
- Antibiotic resistance;
- Route of infection (needle sharing, food poisoning, etc); and
- Sequence of conditions leading to death.

Malnutrition, Cachexia, Inanition

Because a diagnosis of malnutrition, cachexia, inanition or any term related to starvation may indicate substandard clinical care, as a result of negligence, misconduct or malpractice, it should always be considered for reporting to the Coroner.

However, if it is judged that any of the above conditions is caused by an underlying natural cause, it does not need reporting e.g. end stage dementia, gastro-intestinal pathology. If there is a decision not to refer such a diagnosis to the Coroner, the entry of that term on a MCCD **must** be qualified to indicate an underlying natural cause.

Old Age, General Debility of Age, Frailty, Senility and Weakness

The use of these indefinite terms is not encouraged. It is preferred that they are not used alone in Part I and without further supporting qualifying particulars (Example 17).

Old age should only be given as the sole cause of death when all of the following criteria have been met. The doctor,

- has personally cared for the deceased over a long period (years, or many months);

- has observed a gradual decline in the patient's general health and functioning;
- is confident that the death was expected;
- is unaware of any identifiable disease or injury that contributed to the death;
- is certain that there is no other reason that the death should be reported to the Coroner's Office; and
- the patient is 80 years or older and all the conditions listed above have been met.

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.

It is possible that families, Registrars and cremation referees may request further explanation of an opinion that 'Old age' was the only cause of death.

Example 17

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ..... HYPOSTATIC PNEUMONIA ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... DEMENTIA ..... due to (or as a consequence of)	.....
	(c) .... OLD AGE	.....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II**	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Diabetes mellitus

Always specify whether diabetes mellitus was insulin dependent / Type 1, or non-insulin dependent / Type 2. If diabetes is the underlying cause of death, specify the complication or consequence that led to death, such as ketoacidosis (Example 18).

Example 18

I	CAUSE OF DEATH	These particulars not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ..... END-STAGE RENAL FAILURE ..... due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... DIABETIC NEPHROPATHY ..... due to (or as a consequence of)	.....
	(c) .... TYPE 1 DIABETES MELLITUS	.....
II **Other significant conditions** contributing to the death, but not related to the disease or condition causing it	**II**	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

Terminal events, modes of dying, clinical signs 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.

Natural Causes

There is no ICD code equivalent to “natural causes”, and Registrars will seek clarification from the doctor, or refer the case to the Coroner. If you do not know what disease caused your patient's death, you should discuss the case with the Coroner.

Substance misuse

Deaths from diseases related to chronic alcohol or tobacco use do not need to be referred to the Coroner, provided the disease is clearly stated on the MCCD.

Deaths due to acute or chronic **poisoning**, by **any** substance, and deaths involving drug dependence or misuse of substances other than alcohol and tobacco must be referred to the Coroner.

Pregnancy, Childbirth

Whenever pregnancy, parturition or miscarriage has been in anyway a contributory cause of death, this fact should be mentioned in the MCCD and the nature of the abnormality, if any, should be provided. If, on the other hand, it is not regarded as a contributory cause, it need not be mentioned on the form.

Maternal conditions as causes of death in the newborn

In general, disease conditions recorded on a death certificate will be conditions from which the deceased suffered. However, in certifying the cause of death of a newborn infant, the practitioner may wish to record underlying conditions in the mother of the deceased infant. This may be done, although it is expected that maternal conditions will usually be regarded as a cause of infant death only in the first 28 days of life. Where maternal conditions are recorded, they should be distinguished as "maternal" (Example 19).

Example 19

I	CAUSE OF DEATH	These particulars, not to be entered in Death Register
Disease or condition directly leading to death*	**I** (a) ..... FETAL ANOXIA	.....
	due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) .... MATERNAL PRE-ECLAMPSIA	.....
	due to (or as a consequence of)	
	(c)	.....
II	**II**	
Other significant conditions contributing to the death, but not related to the disease or condition causing it	..... PREMATURITY	.....
	.....	.....

* This does not mean the mode of dying e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.

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Information required before completing the Initial Record of Death (IRD) on NIECR.

1	Patient details,	Name Health & Care number DOB
2	Date and Time of Death	
3	Name of who verified death	
4	Place of Death	
5	Initial Reviewing M&M team & Consultant	
6	Clinical Details - SBAR	Admission and clinical course details
		Diagnosis
		Past Medical History
		Medications
		Procedural Details, Surgery
		Investigations
7	Outcome following death	MCCD issued, contact with Coroner details, Death outside NI, etc.
8	Coroner's Reference Number	If you have contacted the Coroner's Office regarding a death, the provided Coroner's Reference Number will need to be entered onto the NIECR.
9	Implant details	Cardiac Device, Pacemaker, Ventricular Assist Device (VAD),
		Implantable Cardio-defibrillator (ICD),
		Implantable drug pumps, Radiopharmaceutical treatment device,
		Radio-active implant,
		Expandable intramedullary device- FIXION™ nail
		Battery Powered or pressurised implant
10	Doctors details	Name
		Work Address
		Work Contact number
		GMC number

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Recording an Initial Record of Death & printing a MCCD on NIECR

Logon to NIECR

- Using your Trust NIECR logon details, logon to NIECR.
- If you do not have NIECR logon credentials, consult DoH "Guidance surrounding Death" website and access 'Details for obtaining NIECR account Requests'.

Access Patient & Enrol on Mortality Pathway

- Ensure you know the deceased patient's name and H&C number.
- From the Home Screen, identify the deceased patient by using the 'Patients' tab.
- If the patient record is locked down, contact NIECR Team to release – Contact details below.
- Once the Patient Summary Screen appears, click on 'Pathways' tab along the top of the screen.
- Click on 'Enroll in Pathway' (located just below 'Pathway Enrollment' heading at top of page).
- From the drop-down list select 'Mortality Pathway' and click on 'Enroll'.
- If you enroll the wrong patient into the pathway, you can "Deactivate" the pathway.

Complete an Initial Record of Death (IRD)

- A form will pop up on the left hand side under 'Mortality Pathway' entitled 'Mortality Initial Record of Death'. Click on this.
- Enter required information on form. Some information will be pre-populated.
- When entering date and time of death, please ensure these are the same as recorded in the handwritten notes as Verification of Life Extinct.
- Answer if the patient died in or out of hospital. Complete the address if they died out of Hospital.
- Place of Death: Select your Trust area, then the appropriate hospital and the ward details.
- Then, the appropriate M&M team and Consultant must be selected to review the death.
- If you do not know the correct Consultant, select the M&M lead for that team. The M&M lead is identified within the team descriptor when you select the M&M team.
- Complete all the required boxes and click '*Complete*' at bottom of form.

Printing MCCD and/or Clinical Summary

- Once you have clicked '*Complete*' on the Initial Record of Death Form there may be output documents for you to print, depending on the outcome you have chosen. These will be an MCCD, a Clinical Summary (for the Coroner), or both.
- To access these, click on the *'Patient Summary'* tab along the top of your screen, followed by 'Notification & Legal Documents' on the left-hand-side. If you would prefer this to appear in a separate window you can select *'Patient Summary Popup'* at the top of the screen.
- After you have clicked on the relevant document there is an option to *Print* at the top of the screen.
- When printing, ensure that 'Fit to Size' is selected within the PRINT dialog box. Otherwise the borders of the MCCD will be cut off.
- Similarly, for printing the Clinical Summary.

Editing a MCCD

- A MCCD can only be edited if it has not yet been provided to the family or left the ward. If it has already been issued and especially if the death has already been registered in the GRO, the MCCD needs corrected during 'Consultant Review' using a MCCD Correction Form.
- To edit the MCCD – enter the patient record, click on the 'Pathways' tab, click 'All' at the top left of the screen under 'Patient Tasks' and click on 'Initial Record of Death' (which will have a ticked green circle beside it). Click '*Re-open Task*' at the top-right of the screen.
- Make the necessary changes to the Cause of Death section & click '*Complete*' at the bottom. The editied MCCD will appear under 'Notification & Legal documents' as before.
- Print the MCCD as before. Ensure the original incorrect MCCD is retained & destroyed.

Contact details

If you are experiencing any issues accessing the NIECR - Mortality Pathway or problems registering a death please contact: NIECR via the Infra portal on the Trust Intranet site (SHSCT, SEHSCT & NHSCT) or supportteam@hscni.net (BHSCT & WHSCT)

Steps needed to complete IRD*, install eMCCD into the Notification & Legal document area to allow printing.

	Action	Note
1.	NIECR logon using user name and personal password	Do NOT use anybody else's logon details.
2.	Select correct patient on NIECR, • by direct patient search using H&C number, or • from recently reviewed patients	Ensure the correct patient is identified
3.	Enrol deceased onto Mortality Pathway	
4.	Select Initial Record of Death	To be found within Clinical Document Viewer (CDV) tree
5.	Check correct patient is selected	
6.	Enter date & time of death	Determined by Verification of Life Extinct date & time.
7.	Enter who verified life extinct (VLE)	
8.	Enter Place of Death	
9.	Select M&M reviewing Team	
10.	Select Additional team, if necessary	
11.	Complete Clinical Detail boxes	Brief summary if NOT Coroner's case
12.	Select MCCD Outcome	
13.	If Coroner's Office contacted for advice, enter the Coroner's Reference Number provided.	
14.	Complete Cause of Death boxes	See **RECORDING THE CAUSE OF DEATH**
15.	Complete Implant questions	
16.	Enter Work address and contact numbers	Use Work numbers only
17.	Enter correct GMC number	Only use your own number
18.	Print eMCCD	Select Patient Summary
		Select Notification & Legal Documents
		Select MCCD
		Hover over MCCD pdf
		Select Print icon
		Ensure 'Fit', 'Shrink to Fit' or 'Print to size' button is selected
		Print
19.	Sign and Date eMCCD	
20.	Hand to informant	Explain details of MCCD to family and informant

* = Initial Record of Death

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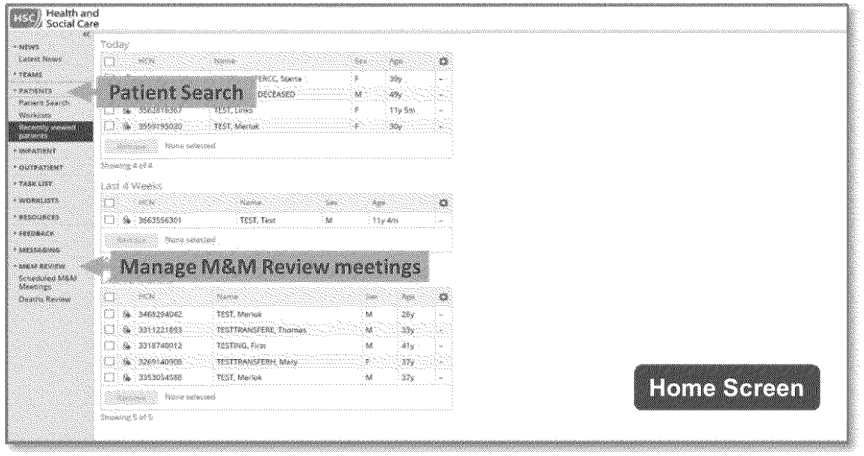
Instructions for printing an eMCCD and/or Clinical Summary from NIECR.

Once logged onto NIECR, there are 3 basic screens that you will need to access during the process of recording a death and printing the eMCCD and/or Clinical Summary.

1. HOME Screen

Following NIECR logon, the first screen entered is the HOME page.



This will allow you to select the correct deceased patient either,

- from their Health & Care number; or
- because they have been a recent encounter on NIECR.

Incidentally, in this screen you can also access “M&M Review” where you can,

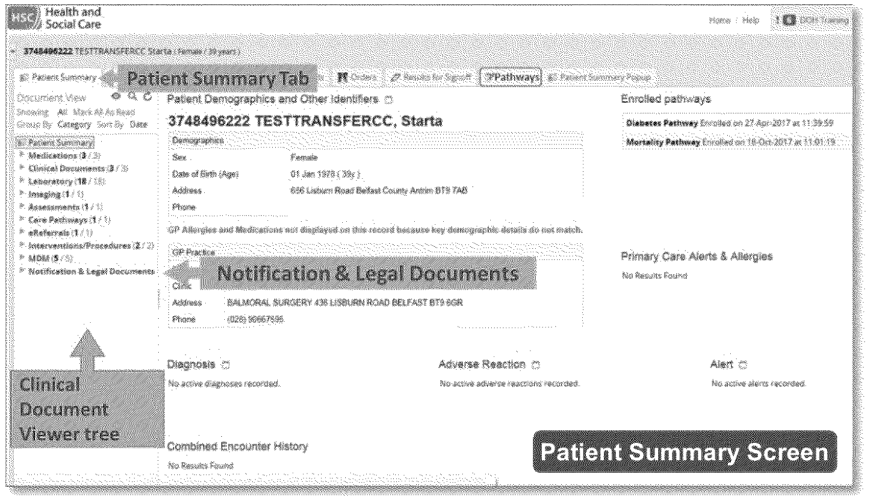
- schedule, access and manage M&M meetings;
- view the Outcome Reports from M&M meetings; and
- access the Death Review List.

Once the correct patient is selected, a second screen, the Patient Summary Screen, will be produced.

2. Patient Summary Screen

The Patient Summary Screen is the main starting point for each patient and includes an area for viewing documents; the Clinical Document Viewer (CDV) tree. In this list, under Notifications & Legal Documents, the following documents are placed which can be accessed and printed from here.

- Medical Certificate of Cause of Death (MCCD);
- Clinical Summary;
- Child Death Notification Form; and
- MCCD Correction Form.



Before doing this, the death must be first be recorded onto the NIECR via the third screen – the Mortality Pathways Screen, which is selected from within the Patient Summary Screen.

3. Mortality Pathway Screen

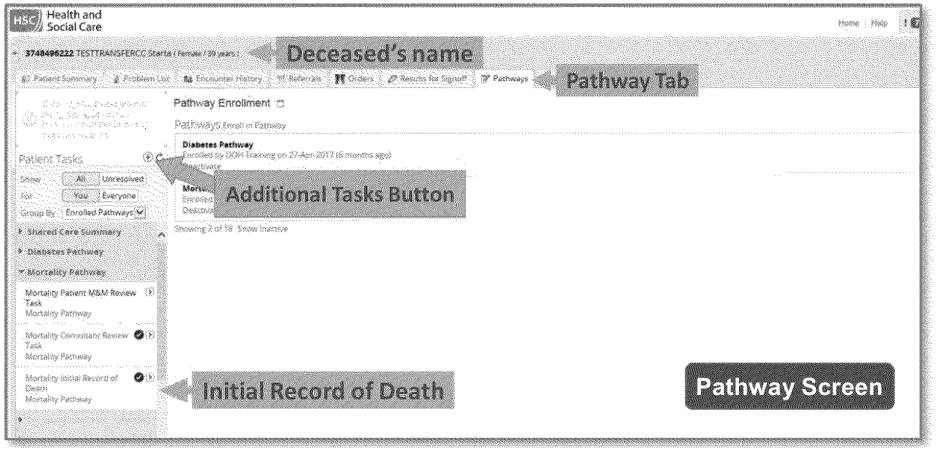
This screen is accessed by selecting the Pathway tab from within the Patient Summary Screen.

The Mortality Pathway Screen allows,

- enrolling the deceased onto a Mortality Pathway which, once completed;
- production of the Initial Record of Death (IRD). This will automatically appear on the left-hand margin.

Completing the IRD requires the following items of information. Once the IRD is completed, printing of the eMCCD and/or Clinical Summary can now be accomplished by returning to the second screen - the Patient Summary Screen, where the Notification and Legal Document area will now contain the eMCCD and/or Clinical Summary.

This whole sequence is summarised in a sequence of screens here



Incidentally, the Mortality Pathways Screen also allows,

- completion of the Consultant Review;
- review of the case at a Patient M&M Review meeting; and finally,
- Patient M&M Signoff.

The Mortality Pathways Screen also contains the "Additional Tasks" button which provides the,

1. ability to 'Add a Document' to the patient NIECR record.
2. opportunity for another patient M&M review, either by the,
    a. Primary Review team; or
    b. an Additional Review Team.

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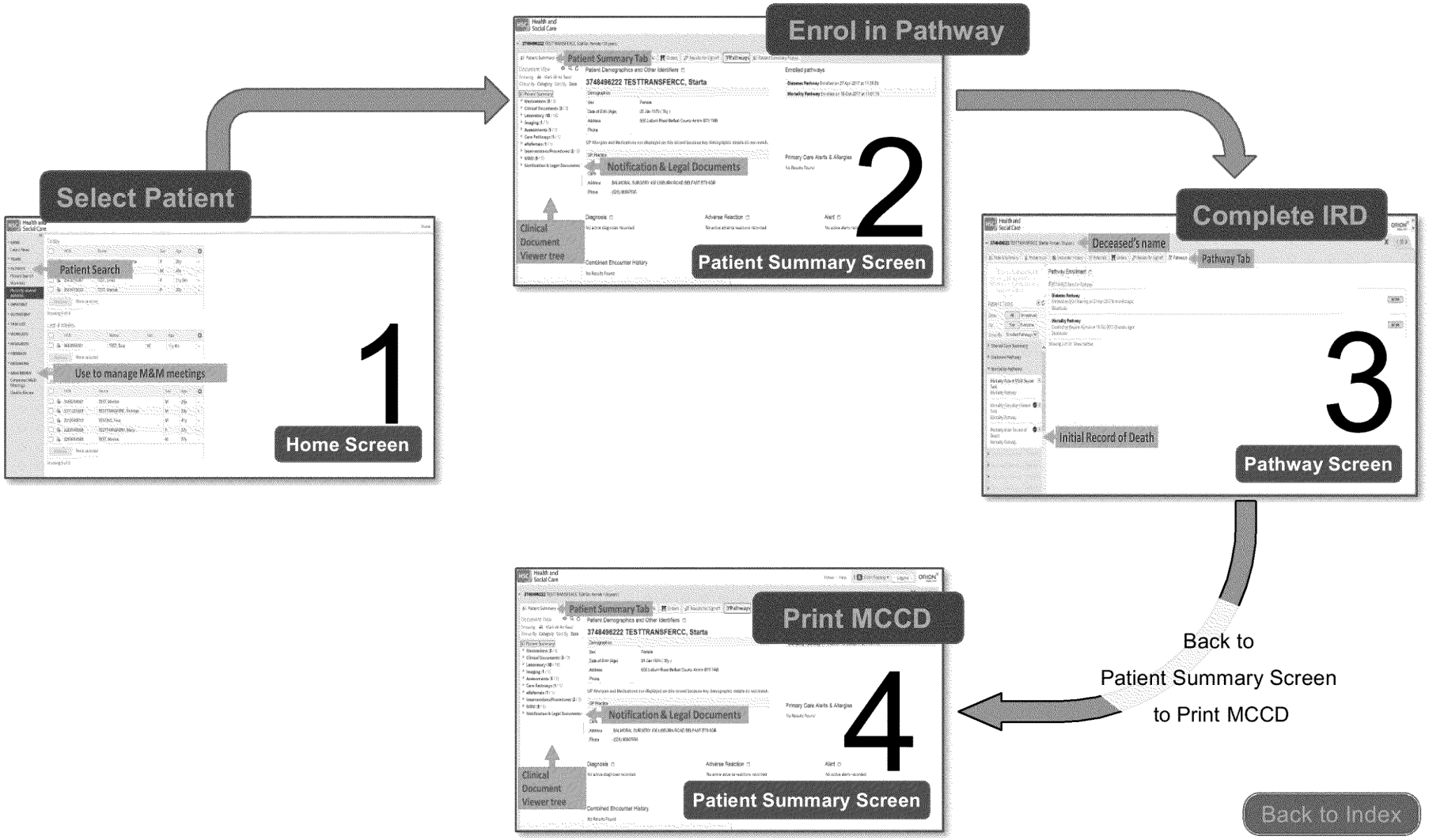
Sequence of Screens required to produce the Medical Certificate of Cause of Death on NIECR



RLIT0002319_0027

Details for obtaining NIECR Account Requests

Belfast HSCT

The Belfast Trust has a registration site setup at:
http://intranet.belfasttrust.local/directorates/par/it/niecr/Pages/Home.aspx

mark.kyle@GRO-C	Project Manager
Lynsey.ONeill@GRO-C	NIECR Project Implementation Manager

Northern HSC Trust

All requests to ECRSupport: ECRSupport@northerntrust.hscni.net

Catrione.Heaney@GRO-C	NIECR System Manager / Trainer
mary.mccluskey@GRO-C	NIECR Implementation Managers

Southern HSC Trust

itservice.desk@southerntrust.hsnci.net	IT Service Desk
Bridin.ohare@GRO-C	IT System Support
Kate.Cunningham@GRO-C	NIECR Transformational Lead

South Eastern HSC Trust

Heather Gibson@GRO-C	NIECR Implementation Manager
Steven.Hutchinson@GRO-C	NIECR Project Support Officer

Western HSC Trust

All requests to WHSCT Helpdesk: ictservicedesk@westerntrust.hscni.net

or by contacting extn 215555

Paula.McGuinness@GRO-C	NIECR/Encompass Lead
LizP.Doherty@GRO-C	NIECR Project Manager
Alisone.Irvine@GRO-C	NIECR Trainer

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