# Information about Death Certification in Wales

## 1 Confirmation of Death

The fact of death needs to be verified by an appropriately qualified clinician, with the date and time of death recorded in the medical record.

## 2 Referral to HM Coroner or the Medical Examiner Service

### 2.1 Coronial Referral

Doctors must refer certain deaths for Coronial investigation. If the Coroner has a duty to investigate, Attending Practitioners do not need to complete a Medical Certificate of Cause of Death (MCCD). If there is no duty to investigate, Attending Practitioners must notify the Medical Examiner Service and complete an MCCD.

### 2.2 Medical Examiner Referral

The Medical Examiner Service for Wales scrutinises every death not investigated by the Coroner. When notifying of a death, Attending Practitioners must share the proposed cause of death or completed MCCD (without abbreviations), medical records and next of kin details. Delays or incomplete/inaccurate information will impede scrutiny and death registration, so all information must be quality assured.

For deaths that appear straightforward, Attending Practitioners should promptly submit an accurate MCCD, relevant medical records and next of kin details. For complex deaths or where the cause is unclear, a QR code form (either a local or Medical Examiner Service template) can be submitted (by an Attending Practitioner or suitably qualified practitioner under their delegated authority) in the first instance to advise of their certifying intentions. Medical Examiner Officers will aim to respond to QR code forms within one working day to provide advice ahead of an MCCD being completed and submitted.

## 3 Independent Scrutiny

Medical Examiners review the medical records, proposed cause of death and discuss with the bereaved family. They look beyond the deceased's final admission, consider the final illness and wider context to determine whether they can support the proposed cause of death and countersign the MCCD. Medical Examiners may need to contact the Attending Practitioner in certain circumstances during scrutiny.

Attending Practitioners and Medical Examiners must make every effort to agree the cause of death. Where agreement cannot be reached, escalation to the Consultant in charge or the Lead Medical Examiner may be required or in rare instances, referral to the Coroner for investigation.

## 4 Death Registration

An appointment will be made to register the death once the Registrar has received the MCCD. A green form will be issued to allow the funeral or burial to proceed.

## 5 Circumstances Requiring Coronial Referral

The following circumstances require notification to His Majesty's Coroner under Regulation 3 of The Notification of Deaths Regulations 2019. Care providers should be familiar with their statutory duties in accordance with the regulations and are advised to refer to the accompanying guidance for further information regarding their application within these circumstances.

A person's death should always be notified to the Coroner where there is reasonable cause to suspect that the death was due to (i.e. more than minimally, negligibly, or trivially caused by or contributed to by) any of the following:

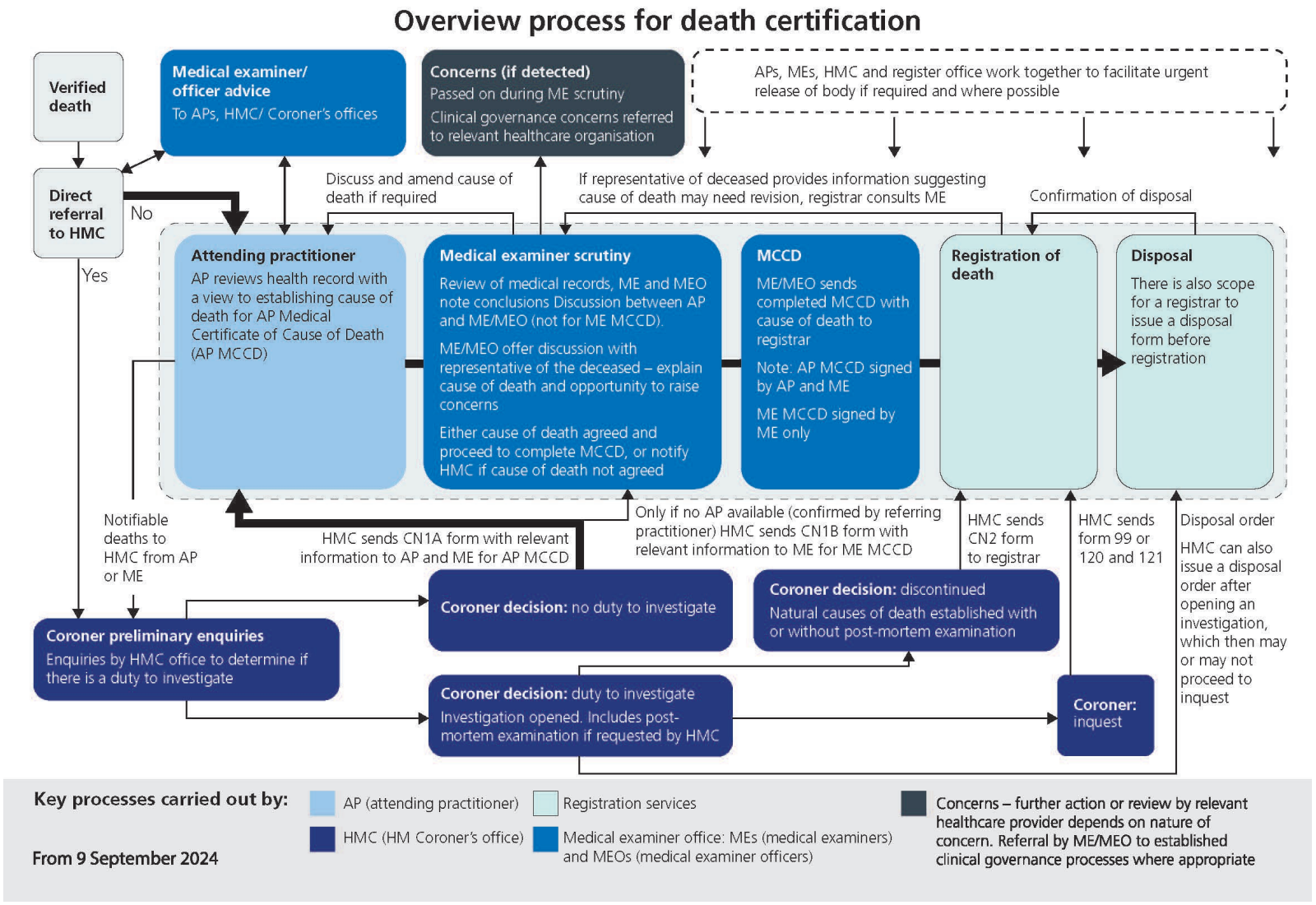
- Poisoning including by an otherwise benign substance
- Exposure to, or contact with a toxic substance
- Use of a medicinal product, the use of a controlled drug or psychoactive substance
- Violence, trauma or injury
- Self-harm
- Neglect, including self-neglect
- The person undergoing any treatment or procedure of a medical or similar nature
- An injury or disease attributable to any employment held by the person during the person's lifetime

In addition, a person's death should always be notified to the Coroner where:

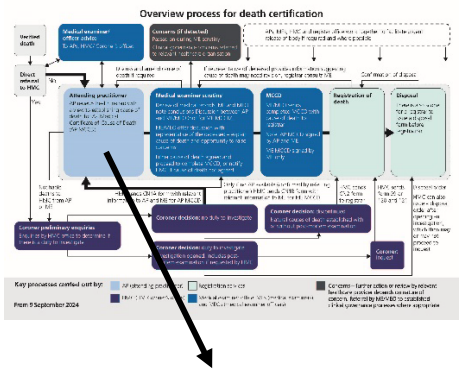
- The registered medical practitioner suspects that the person's death was unnatural, but does not fall within any of the above circumstances
- The cause of death is unknown
- The registered medical practitioner suspects that the person died while in custody or otherwise in state detention
- There is no attending practitioner, or an attending practitioner is not available within a reasonable time to sign a MCCD in relation to the deceased person
- The identity of the deceased person is unknown

The length of time that has passed since the person died does not impact on the duty to notify a Coroner of the death once relevant circumstances come to light.

## 6 Death Certification Flowchart



## 7 Attending Practitioner Responsibilities




### Attending Practitioner (AP) Responsibilities

**Determining the AP**

**1.** If you have medically attended the deceased during life and can determine / ascertain the cause of death, you can act as the AP for death certification.

**2.** If you have not medically attended:

- Try to identify a suitable alternative AP.
- If unsuccessful, escalate to the Consultant / GP in charge to either identify an AP or act as the AP (where possible).
- If still unsuccessful, refer the death to HM Coroner.

**Death Notification**

**1.** AP to review the clinical records and determine the likely cause of death.

**2.** Determine whether the death meets the Notification of Deaths Regulations (2019) criteria. If yes, refer to HM Coroner immediately. If no, notify the Medical Examiner (ME) Service.

**3.** If notifying the ME Service, complete the MCCD, gather clinical records (or access to them) and next of kin details. Ensure all parts of the MCCD are complete, accurate and without abbreviations.

**Submitting the MCCD**

**1.** If the death appears straightforward (following discussion with a senior doctor if required), submit the completed MCCD to the ME Service as soon as possible.

**2.** If there is uncertainty about the cause of death, complete a QR code form (either local or ME Service template) to receive ME Officer advice (responses usually received within 24 hours). Submit the MCCD immediately thereafter.

**Medical Examiner Scrutiny**

ME's and AP's may need to discuss the proposed cause of death. In some instances, the MCCD may need to be revised and resubmitted (i.e. changes required following family feedback or disagreement about the cause of death).