Pandemic Influenza: Guidance on the management of death certification and cremation certification

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Pandemic Influenza: Guidance on the management of death certification and cremation certification in a pandemic

Prepared by

The Department of Health

The Ministry of Justice

The General Register Office

Contents

Introduction

Management of deaths resulting from an influenza pandemic

This guidance document forms one of three pieces of guidance produced by Government to support planning for the management of the excess deaths resulting from an influenza pandemic.

As set out in the UK Influenza Pandemic Preparedness Strategy 2011, depending upon the virulence of the influenza virus responsible for a pandemic, the susceptibility of the population and effectiveness of countermeasures, up to 2.5% of those who are symptomatic with flu may die. Based on the UK population size, that equates to up to 750,000 additional deaths over the period of the pandemic (i.e. deaths that would not have happened over the same period of time had a pandemic not taken place).

These increases to the numbers of natural deaths in a potentially short period of time will place considerable pressure on local service providers. It is therefore essential that Local Resilience Forums, Local Authorities, the NHS, registrars, coroners and other service providers (including any private or public organisations involved in the management of deaths) develop plans for this eventuality.

Together with this guidance document, the other two guidance documents supporting planning in this area are:

- The Home Office guidance ‘Planning for a Possible Influenza Pandemic – A Framework for Planners Preparing to Manage Deaths’. This offers advice to local authorities and service providers who are responsible for producing and maintaining emergency and business continuity plans associated in the management of excess deaths.
- The Ministry of Justice guidance ‘Pandemic Influenza: Guidance for Coroners and Planners in England and Wales’. This guidance is intended to assist coroners, local authorities and Local Resilience Forums to prepare for and mitigate the effects of an influenza pandemic. It is designed to ease the pressure on coroners’ services and provide coroners with greater discretion in the event of an influenza pandemic. The Guidance applies to the current system under the Coroners Act 1988 and Coroners Rules 1984. The Chief Coroner, once in post, will work with the Ministry of Justice to review and amend this Guidance as appropriate, reflecting the changes to be introduced under the Coroners and Justice Act 2009.

Guidance on the management of death certification and cremation certification in a pandemic

Summary of proposals

This guidance is intended:

- To assist medical practitioners with their responsibility for the appropriate certification of deaths in the event of an influenza pandemic
- To assist cremation and burial authorities in managing their responsibility for the disposal of remains.

It will also be relevant to planners in local authorities and the NHS, funeral directors, registrars and coroners. Parallel guidance on preparing for and responding to deaths arising from a pandemic is available for registrars, coroners and local planners. The guidance applies to England and Wales. It has been shared with Scotland and Northern Ireland who are considering these matters in their own jurisdictions.

The guidance sets out different ways of working and other measures to help manage the pressures that are likely to arise during a pandemic. These include measures agreed locally and those that will be implemented on a mandatory, national basis.

At local level, Local Resilience Forums (LRFs) (and Strategic Co-ordinating Groups (SCGs) during the response to the pandemic), in discussion with the local coroner, will be able to agree to suspend the common (non-statutory) practice of reporting all deaths which occur within 24 hours of admission to hospital to the coroner insofar as it concerns deaths caused by pandemic flu or complications thereof.

In addition, the following different ways of working, summarised below, will be implemented as “Phase Three, Section Two” changes under the Home Office Framework for managing deaths in a pandemic. This means that they require national legislative changes which will be instigated centrally when the level of pressures experienced at local level are such as to require them. All areas must change to these different ways of working when notified.

I. The legal requirement in Regulation 41 of the Registration of Births and Deaths Regulations 1987 that a death must be referred to the coroner if the registered medical practitioner (who must have attended the deceased during their final illness) who certified the cause of death had seen neither the body after death nor the patient within 14 days of their death, will be relaxed to refer to 28 days.

II. Legislative amendments will be made that allow a registered medical practitioner who has not attended the deceased in their final illness to provide a medical certificate of cause of death (MCCD) for those who appear to the best of their knowledge and belief to have died of pandemic influenza and to complete form Cremation 4.

III. Legislative amendments will be made to the Cremation Regulations 2008 to introduce a streamlined version of form Cremation 4 and to suspend the requirement for form Cremation 5.

Scope

1. This guidance applies to England and Wales. It has been shared with Scotland and Northern Ireland who are considering these matters within their own jurisdictions.

Context

2. The Home Office has issued guidance on *Planning for a possible influenza pandemic: A framework for planners preparing to manage deaths*. This guidance should be read alongside the Home Office guidance, which covers the entire process of the management of deaths.

3. Responsibility for different aspects of the process after someone dies is spread across a range of government departments. In order to manage deaths effectively, the process of completing a Medical Certificate of Cause of Death (MCCD) needs to be considered within the framework of the entire 'death to disposal' process. The guidance set out below is based on this principle.

General approach

4. Death certification is an important process. It provides assurances to the relatives and friends of the deceased concerning the cause of death and of the absence of misconduct in relation to the death. It also plays an important role in public health surveillance. Where the deceased is to be cremated, cremation certification provides additional safeguards. Particular concerns arise when a person dies whilst in the custody of the state (for example, in prison), and in normal circumstances enhanced safeguards are applied in such cases.

5. Medical practitioners play a key role in both death and cremation certification. Decreasing the safeguards within the present system of death and cremation certification would be a serious step that requires justification. An influenza pandemic could lead to 25–50% of the UK population becoming ill, and between 55,000 and 750,000 excess deaths in the UK over a 15-week period.

6. *Responding to pandemic influenza: The ethical framework for policy and planning*[1] contains ethical principles that should inform the UK's response. In the context of death and cremation certification, the principles of minimising harm and of proportionality are of particular importance. A balance needs to be struck between ensuring medical practitioners are able to focus on the needs of the sick and the provision of safeguards for those who are deceased. How that balance is struck will depend on the actual pressures experienced during a pandemic.

7. Maintaining continuity of business, using the current legislative framework, maintaining public safety, ameliorating anticipated pressures and being sensitive to the needs of friends and relatives of the deceased person also underpin the proposals. The guidance takes account of the consultations on the process of death certification following the Shipman Inquiry. The outcome of those consultations might lead to further changes.

8. In May 2012 the Lord Chief Justice announced the appointment of His Honour Judge Peter Thornton QC as the first Chief Coroner of England and Wales. He will take up post in September 2012 and will work with the Ministry of Justice to review and amend pandemic guidance in relation to the operation of the coroner system as appropriate. This should not affect planning assumptions.

9. LRFs play a key role in planning for an influenza pandemic and are responsible for agreeing the procedures across services to apply in their particular localities. Changes to the way in which an organisation's business is conducted will take place in Phases and will have different trigger points:

   - Phase One, it will be for individual organisations to implement their own business continuity arrangements, in line with their single-agency business continuity plans.

   - Phase Two, will involve the implementation of measures which require a co-ordinated approach between one or more organisations. LRFs will have an important role to play in identifying the other key players and agreeing a Plan, including trigger points for coordinated implementation of different ways of working, in advance of the pandemic.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080751

- Phase Three, at this stage changes to primary and secondary legislation may be implemented by Ministers. During Section One of this phase, statutory changes which affect a single business area e.g. coroners will be **made available.** At Section Two, statutory changes which have implications for more than one business area may be brought in. An example of this is an amendment to the process of death registration. This would affect both the registration service and the funeral sector. The trigger point for this phase will be requests by one or more Strategic Co-ordinating Groups (SCGs) for uniform implementation of one or more Section Two changes. More detailed information about these Phases is provided in the Home Office guidance: *Planning for a possible influenza pandemic: A framework for planners preparing to manage deaths*[2].

10. During a pandemic SCGs are likely to be convened to take overall responsibility for the multi-agency management of an outbreak at local level.

11. The challenges of an influenza pandemic are far reaching and require a cross-society approach. As with all emergencies LRFs take primary responsibility for developing preparedness plans for an effective operational response to major emergencies and therefore local responders have existing coordinated plans and arrangements in place which would shape the response to a pandemic. As new organisations are formed planning will need to review and reflect the changes in structure and capacity available to deliver the response.

12. In this guidance, all references to a 'medical practitioner' refer to a registered and licensed medical practitioner unless otherwise indicated. You need both to be able to sign death certificates. Medical practitioners who provide certification of the cause of death to the best of their knowledge and belief must be satisfied to the best of their knowledge and belief as to the likely cause of death. The information available to inform that view may be different during a pandemic to normal circumstances.

Current practice

13. The current requirements for death and cremation certification are not always well understood and are described in the appendices:

- **Appendix A** provides an overview of the current system for death and cremation certification for England and Wales and the forms that must be completed as part of the 'death to disposal' process.

[2] Available at: http://www.ukresilience.gov.uk/~/media/assets/www.ukresilience.info/flu_managing_deaths_framework%20pdf.ashx

- **Appendix B** describes the process for certification and registration of deaths in the constituent parts of the UK. Annexes describe the requirements for reporting deaths to coroners/procurators fiscal in the different jurisdictions.
- **Appendix C** sets out the requirements for cremation across the UK.
- **Appendix D** is a proforma aimed at assisting the death certification process during a pandemic.
- **Appendix E** provides checklists for planning purposes.

14. Where the proposed method of disposal is by burial, authorisation is effected by a coroner's burial order or the registrar's disposal certificate (normally following registration of the death). No changes to these requirements appear to be needed or are proposed for the purposes of facilitating burial in the context of an influenza pandemic.

Verification of death

15. The completion of an MCCD must be distinguished from verification that a person has died. Such verification allows the body to be moved from the place of death to a mortuary or the premises of a funeral director. In some areas of England and Wales, registered nurses are already able to verify death; as a matter of professional good practice they must ensure that they are competent to do so if they carry out this role. Ambulance staff are also able to verify death.

16. Efficient verification of death is important for ensuring an effective and seamless process towards disposal. Deceased persons should not be taken to hospital for verification of death. Local consideration should be given to making sure that there is clear agreement on which individuals, and in which circumstances, can verify death. If it would be useful for nurses who do not normally verify death to do so in a pandemic, appropriate training should be provided to ensure that the nurses concerned consider themselves competent to perform this role.

Different ways of working: certification of cause of death

17. Consideration was given to the possibility of widening the pool of people who might complete the MCCD beyond registered medical practitioners. However, it is anticipated that it will be possible to expand the pool of registered medical practitioners sufficiently to render this unnecessary by employing, in particular, retired practitioners or those willing to return to the medical register for the duration of an emergency such as pandemic. Therefore, the Government does not plan to make provision for people other than registered medical practitioners to undertake certification of death.

18. This guidance is intended to assist medical practitioners with their clinical responsibility for the appropriate certification of deaths in the event of an influenza pandemic. The UK Influenza Pandemic Preparedness Strategy (November 2011), advises that local planners should prepare to extend capacity on a precautionary but reasonably predictable basis, and aim to cope with a population mortality rate of up to 210,000-315,000 additional deaths possibly over as little as a 15 week period and perhaps half of these over three weeks at the height of the outbreak. More extreme circumstances would require the local response to be combined with facilitation or other support at a national level. In a less widespread and lower impact influenza pandemic, the number of additional deaths would be lower.

19. During a pandemic, there will be considerable pressure on medical practitioners. Whilst ensuring that the process from 'death to disposal' is effectively and sensitively managed, the process described below should also ensure that practitioners are able to devote as much time as possible to the needs of the sick. At higher case fatality rates other services, in particular the coroner service, as well as burial and cremation authorities, will also be under considerable pressure.

20. The process below aims to maintain 'business as usual' for as long as possible. Changes would only be made to procedures if pressures on medical practitioners and others indicated that these were necessary. Each step in the process is designed to respond to increasing levels of pressure, balancing the risk of introducing different ways of working in terms of decreasing safeguards within the processes against the harm that could be minimised by reducing the demands of the processes on medical practitioners and hence allowing them to focus on sick people.

21. The different ways of working, set out at paragraph 24 and following below, will be implemented as "Phase Three, Section Two" changes under the Home Office Framework for managing deaths in a pandemic. This means that they require national legislative changes which will be instigated centrally. All areas must change to the different way of working when notified.

22. The Government's Civil Contingencies Committee will decide on the timing of the introduction of the new arrangements, at national level, in response to one or more requests from SCGs, via the Regional Civil Contingency Committees and the Department of Health for the additional measures that will be available. The decision will take into account:

- information on the demands on medical services from primary and secondary care sources and on the capacity of those services to meet the demands
- available information on deaths, and whether delays in provision of death and cremation certificates are leading to problematic delays in disposal from burial/cremation authorities and coroners

- available information about the likely evolution of the pandemic (for example, based on experience reported from across in the country or from modelling results provided centrally).

Provision of MCCDs for patients who die in hospital

23. The arrangements for provision of MCCDs relating to patients who die in hospital, or in what is anticipated as being the relatively rare case of people who die elsewhere in the presence of a medical practitioner (for example, a patient who dies in a care home whilst a medical practitioner is on site) should proceed broadly as normal throughout.

24. However, in respect of deaths from pandemic influenza occurring within 24 hours of admission to hospital an exception to the rule concerning referral to the coroner will be introduced. Under normal circumstances, coroners strongly encourage that all deaths which occur within 24 hours of admission to hospital (unless purely for terminal care) are reported to them. This is not a statutory requirement.

25. At local level, LRFs (and SCGs during the response to the pandemic), in discussion with the local coroner, will be able to agree to cease the common (non-statutory) practice of reporting all deaths which occur within 24 hours of admission to hospital to the coroner insofar as it concerns deaths caused by pandemic flu or complications thereof. The aim of this is to reduce pressure on hospital doctors, coroners and, potentially, pathologists. The statutory requirement to report all deaths that occur during an operation or before recovery from the effects of an anaesthetic will not be changed.

Deaths in other circumstances

26. Where a patient dies in other circumstances, the following different ways of working will apply.

Reducing the number of deaths referred to the coroner under the '14 day' rule

27. Normally, when a doctor attends a patient during their final illness, the death must be referred to the coroner if the doctor who certified the cause of death has seen neither the body after death nor the patient within 14 days of their death.

28. To alleviate the pressure of excess deaths, one or more SCGs may request Ministers to introduce legislation to relax the limit from 14 to 28 days. This would bring England and Wales into line with current practice in Northern Ireland. Where a patient has a chronic condition and death is not unexpected, this will decrease the need for doctors to make visits for the purpose of seeing the body, reduce the need for doctors to contact the coroner, and reduce pressure on coroners and possibly on pathologists for post-mortems. This will require legislative change that will be introduced at national level.

29. The implementation of this change will be announced centrally and the information cascaded to SCGs, registrars and coroners.

Increasing the number of medical practitioners authorised to certify the cause of death.

30. If the clinical attack rate and case fatality rate during the pandemic are at the upper end of the range, services are likely to be under intense pressure.

31. Where a patient is undergoing treatment for another condition that subsequently causes the death of the patient, the doctor who attended the patient in their last illness will be expected to certify the cause of death by completing the MCCD as normal and, providing they saw the patient during the last 28 days before death, the death will not need to be referred to the coroner.

32. However, where the patient was attended by the doctor for pandemic flu, or where the patient was not seen by a doctor in the last 28 days, the following arrangements will be introduced.

33. At a national level, one or more SCGs may request the introduction of legislative amendments that allow a registered medical practitioner, who has not attended the deceased in their last illness, to certify those who appear, to the best of their knowledge and belief based on the information available, to have died of pandemic influenza. This proposal aims to facilitate provision of MCCDs for those who have died at home and to reduce pressure on doctors in the community, coroners and pathologists. As before, the initiation of this step will be announced centrally and disseminated to all SCGs, registrars' and coroners' offices.

34. In some cases, there may have been little or no recent medical intervention and the medical practitioner may only be able to obtain limited information about the deceased's recent state of health. The medical practitioner should consider the information that is available and any other relevant circumstances (for example, any evidence that the deceased contacted the National Flu Line Service; or the existence of medication suitable for treating pandemic influenza, such as oseltamivir in the deceased's possession, with an indication that at least part of the course has been utilised). Where possible, the medical practitioner should also have access to the GP records for the individual and the general practice concerned should make these available. Medical practitioners should also be provided with appropriate identification.

35. Appendix D provides a proforma for collecting information on the deceased to assist this process. This proforma will be made available electronically on the Department of Health and Welsh Government websites and will be amended if necessary to take account of emerging information about the particular symptoms associated with pandemic influenza. It should be retained as evidence of the information available on which the MCCD was signed. The present proforma is based on the provisional clinical management guidelines drawn up by the British Infection Society, the British Thoracic Society and the Health Protection Agency.[3]

36. If the medical practitioner is not able to confirm that, to the best of their knowledge and belief based on the information available, the death is due to pandemic influenza, referral to the coroner will be required. There may be cases where the medical practitioner has found some evidence of symptoms and/or surrounding circumstances that are compatible with, but not exclusive to, pandemic influenza as the cause of death. In such a case, if there are no other indications as to an alternative cause of death, and where there are no suspicious circumstances, during a pandemic a post-mortem examination may not be considered appropriate (in order to prioritise pathologists' time for deaths that are due to violence or are otherwise suspicious). After discussion between the medical practitioner and the coroner, the former may conclude that an MCCD can be provided, even if it just records the cause of death as 'natural causes'. This will be acceptable to the registrar. The death can therefore be registered and disposal of the body can proceed.

37. In some circumstances, the coroner may decide that an inquest is appropriate. It will be difficult to hold inquests during the peak of a pandemic, and inquests may be opened and adjourned until the pandemic period has clearly ended. However, the coroner should still be able to provide certification allowing disposal of the body prior to the inquest.

38. Prior to a pandemic, primary care trusts (PCTs)[4], or local health boards (LHBs) or trusts in Wales, are asked to develop and keep up-to-date lists of people who would be willing to assist during a pandemic. Retired medical practitioners, including those who may have retired or have not practised medicine actively for a considerable period, may be of significant assistance for the purposes of death certification. This is discussed further in paragraphs 45–49 and 55–60 below.

39. PCTs/LHBs/trusts will also need to coordinate a system to inform a medical practitioner of the need to provide, where appropriate, an MCCD. This is discussed further in paragraph 71 below.

[3] Available at: www.dh.gov.uk/pandemicflu

[4] PCTs will be abolished in April 2013 – see paragraph 11.

Streamlining Cremation Certification

40. Legislative amendments would be introduced nationally that would enable a streamlined version of form Cremation 4 to be completed and the requirement for form Cremation 5 to be suspended. Form Cremation 10, from the crematorium medical referee, would still be required as normal. Legislative amendments would also be introduced to remove the requirement for the doctor signing form Cremation 4 to have attended the deceased before death.

41. Medical practitioners providing the streamlined form Cremation 4 would, as now, need to attend the deceased for the purpose of considering whether the body is suitable for cremation. This activity might be particularly suitable for retired medical practitioners (see paragraphs 45 - 49 below). Where the attending doctor during the patient's last illness is able to sign the MCCD without seeing the body (see paragraph 29 above), it would then be open to them to refer the case to the 'locum' doctor to complete form Cremation 4. PCTs will need to ensure that arrangements are in place for rapid referral of such cases.

42. The doctor completing the streamlined form Cremation 4 would need to obtain relevant information from informants such as relatives and other members of the household, external examination of the body and, where possible, from medical records. Certain implants, such as pacemakers, implantable cardiac devices and fixion nails (which may be used to treat certain fractures) are capable of exploding when exposed to high temperatures. This may cause significant damage to the crematorium infrastructure. For this reason, such implants must either be removed (as in the case of pacemakers) or made safe (in the case of fixion nails, by reducing the pressure inside the nail by drilling a hole in it) prior to cremation. In addition, radioactive implants and/or substances used in clinical treatments may pose a hazard for crematorium staff.

43. The external examination of the body is also used to assess whether there are any signs that might indicate an alternative cause of death. In particular, the aim should be to assess whether there is any indication that the death is due to violence or suicide, or is in any way suspicious. Where the medical practitioner is in any doubt he/she must refer the death to the coroner as usual.

44. The suspension of form Cremation 5 will remove the need for a second doctor to confirm the assessment in form Cremation 4. This is intended as a temporary measure to enable doctors to focus on care for the living. The medical referee at the crematorium will continue to review the information in form Cremation 4, discussing with the medical practitioner as required, and to refer to the coroner any cases about which they have doubt.

45. As in the case of the MCCD, the introduction of this alternative way of working in a particular locality will be decided centrally in the light of pressures on services and the factors described in paragraph 20 above.

46. The Cremation Regulations 2008 also provide that a Medical or Deputy Referee appointed by the Secretary of State for Justice may in emergencies act as a Medical or Deputy Medical Referees for a Cremation Authority, other than the one for which they were appointed.

Human resources

47. PCTs/LHBs/trusts should develop and keep up-to-date lists of people who may be willing to assist in a pandemic. Retired doctors may be of particular assistance with regard to death and cremation certification. Doctors need to be informed of this possibility and encouraged to contact their PCT/LHB/trust if they are willing to assist in a pandemic. The British Medical Association has also established a database of retired doctors who are willing to assist in an influenza pandemic.

48. Not all such doctors maintain their registration with a licence to practise with the General Medical Council (GMC), although many may. If medical practitioners are no longer registered, the GMC may return them to the register dependent upon the emergency declared and the need for an increase in licensed doctors. If a doctor is willing to help in the emergency, they should be asked to inform the PCT/LHB/trust when registration is obtained and this should be noted on file. The GMC will show all doctors who hold 'Temporary Registration (Emergency) or TR(E) on the register at www.gmc-uk.org where employers can verify a doctor's details. Doctors who have not been in clinical practice for some years, for example more than five years, may be naturally hesitant about their fitness to return to clinical practice. However, such doctors may still be able to assist in certifying death or acting as a medical referee, acting responsibly within the scope of GMC guidance on responding to emergencies. In addition, legislation is in place which permits the Registrar, under new emergency powers, to make the grant of registration with a licence to practice subject to conditions. This new type of registration is called 'Temporary Registration (Emergency) or TR(E). The GMC has indicated that it should be able to re-register doctors, who have voluntarily left the register, in a timely manner if a pandemic was imminent.

49. At present the GMC does not intend to charge a fee for those who are granted the specific type of registration 'Temporary Registration (Emergency) or TR(E). Temporary staff will be covered by NHS indemnity insurance arrangements providing there is a clear contractual relationship with an employer.

50. As well as contributing to the process of death certification, doctors may also be able to assist by taking on the role of medical referee in local crematoria, subject to their appointment by the Ministry of Justice, in order to relieve pressure on existing medical referees and promote business continuity in the event of sickness absence of medical referees. It will be desirable for the Ministry of Justice to make such appointments long before the pandemic reaches its height. Appropriate training for the role would be required (see paragraph 50 - 54). Appendix A describes the role of the medical referee. To be appointed as a medical referee, a doctor must be a registered medical practitioner of not less than five years' standing. Although five years' continuous registration prior to appointment is desirable, it is not mandatory, as long as the medical practitioner has been registered for more than five years in the past and is registered at the time of appointment.

A doctor should **never**, as a matter of good practice, both issue an MCCD and act as a medical referee in respect of the same individual, given that the form Cremation 5 procedure may be suspended. In addition, as a matter of good practice, a doctor who is a relative, or who may have any pecuniary interest, including the possibility of inheriting from the estate of the deceased, should not take part in the certification process relating to that person.

Training

52. Under normal circumstances, delays may occur in disposal of a deceased person because of inadequacies in completion of the MCCD. For example, heart failure is not a cause of death, but a mode of death. As a result, delays are introduced as the registrar needs to make enquiries either with the certifying doctor or the coroner before s/he can issue the authority for disposal. Poor completion of certification also limits the accuracy of national data.

53. Training in the proper completion of MCCDs and cremation certificates is therefore of importance in normal times. In preparing for a pandemic, planners both in PCTs/LHBs/trusts and in secondary care should consider the adequacy of their existing processes for training staff in this area. It is essential that training covers specific issues relating to pandemic flu, assessing the suitability for cremation and the importance of excluding foul play.

54. Doctors who are willing to assist in providing death certification during a pandemic, or in acting as medical referees, will also need training if these are not tasks they have undertaken recently. PCTs/LHBs/trusts should ensure that doctors are clear on what their responsibilities will be and have access to adequate and appropriate training in the run-up to a pandemic (for example, by offering training sessions, in conjunction with the relevant cremation authority, meeting the local registrar and coroner / procurator fiscal and their teams, etc as appropriate).

55. Through the LRF, PCT/LHB/trust coordinators should contact those responsible for local crematoria to ensure that they give supplementary medical referees access to the guidance normally provided for medical referees.

56. The Department will also be providing some basic training material that explains what Pandemic Flu is about on its PanFlu Forum.[5] A set of slides summarising the arrangements set out in this document will also be made available from the pandemic flu website. These may be helpful in designing training scenarios.

Operational management

Human resources

57. When it is clear that a pandemic is imminent, for example at WHO Phase 5, PCTs/LHBs/trusts should contact the medical practitioners on their list, as well as inviting others to come forward (for example through local media). They should also liaise with the BMA to identify the retired doctors within the local area who are included in the BMA database.

58. Only registered and licensed medical practitioners can complete an MCCD. PCTs/LHBs/Trusts will need to clarify the doctors' registration status on the GMC's List of Registered Medical Practitioners[6] and any doctors who are not registered and who would be willing to assist in death certification should be asked to contact the GMC in order to re-establish their registration as soon as possible. They will also need to ensure the accuracy of contact details such as mobile phone numbers.

59. In the event that a PCT/LHB/trust considers that it may have insufficient medical practitioners to respond to the potential need for provision of death and cremation certification during a pandemic, it should discuss the issue with neighbouring PCTs/LHBs/trusts. As some areas may be more attractive to retirees/returners than others, some PCTs/LHBs/trusts may have a larger pool of retired medical practitioners than others to call upon, and mutual aid may be possible.

60. As with others assisting during a pandemic, the PCT/LHB/trust should have an appropriate, simple, written arrangement for terms and conditions of service with medical practitioners providing death certification, and should ensure that they have appropriate indemnity. These should be tailored to the services they are being recruited to provide. The *Pandemic influenza: Human resources guidance for the NHS* provides further details on this issue.

[5] Available at: http://www.workplaces.dh.gov.uk/panflu
[6] www.gmc-uk.org

61. Those responsible for crematoria will need to make contact with those who have indicated that they are willing to act as medical referees to ensure that they can be properly appointed. All medical referees will continue to be medical practitioners of at least five years standing duly appointed by the Ministry of Justice.

62. The PCT will need to clarify that the medical practitioners have received appropriate training for their roles (including awareness of the functions of the local register office (see paragraphs 63–68), the need for appropriate security for books of MCCDs, and good infection control (see paragraphs 74–76) and whether any updating is required.

Resources needed during the certification process

63. PCTs/LHBs/trusts should also, in advance of a pandemic, consider the resources needed to complete the certification processes and ensure that these will be available (in particular books of MCCDs and proformas to assist in assessment). Such resources will include:

- books of MCCDs
- Streamlined form Cremation 4s. This will be available to download on-line from the UK Resilience website.[7]
- copies of proformas to assist in assessment
- contact details of the relevant coroner's office
- contact details, including fax number and email address, of the local registrar
- surgical masks and other personal protective equipment that may be needed for visits to homes where household members have pandemic influenza
- information booklets about what to do after someone dies.

64. Books of MCCDs are normally supplied to registered medical practitioners by their local registrar, who in turn orders stocks from the General Registrar Office (GRO). Registrars have to keep a record of which books they issue and to whom. PCTs/LHBs/trusts will need to contact their local register office about supplies; preliminary enquiries should be made at an early stage to ensure that stocks can be ordered in good time.

Working with local register offices and cremation authorities

65. PCTs/LHBs/trusts also need to inform local registrars of the names and qualifications of the additional registered medical practitioners they deploy, so that delays are not introduced by the need for registrars to check up on names that are not included in their normal lists.

[7] Available at: http://www.ukresilience.gov.uk/pandemicflu.aspx

66. In some circumstances (see paragraph 72 below), it may be helpful for the medical practitioner (or a member of staff from the PCT/LHB/trust/practice, as appropriate) to either fax or, if facilities are available, scan and email the MCCD to the registrar. As the MCCD is not a standard A4 shape, it is important to establish in advance of a pandemic that such systems are feasible locally. Therefore, PCTs/LHBs/trusts should check with the local register office what systems would be acceptable to it, involving local primary care premises if medical practitioners certifying death would use those premises in a pandemic. Acceptable routes of transmission should be tested in advance of a pandemic with an MCCD to ensure that documents arrive securely, are legible on receipt, and are not corrupted en route.

67. Personal attendance at the local register office can be helpful for relatives. Medical practitioners providing certification need to be informed of the services that such offices provide in order to give that information to bereaved relatives if necessary. In a pandemic, in order to limit the spread of infection, local authorities could decide that they want to limit face-to-face registration by the relatives of the deceased at the local register office. In these circumstances telephone registration may be offered, but this will be possible only if the registrar receives the MCCD or documentation from the coroner by email, fax or another method (see paragraph 72 below). Another option, if their capacity permits, is to use the funeral director (with the authority of the relatives) as an intermediary to take MCCDs to the register office, supply the other information required, and then take disposal documents to the crematorium or burial authority.

68. It may be helpful if medical practitioners have a supply of booklets about what to do after a death[2] which can be given to bereaved people who are not able to, or are asked not to, attend the local register office. The services provided by the local register office include the following (all these services can also be provided by post on request):

- Each person attending to give information about a death is provided with booklets about what to do after a death, which cover arranging a funeral, benefits, probate etc.
- A free notification of death document is issued, which can be used for social security purposes to enable settlement of outstanding claims and payments, including claims for help with funeral costs.
- An addressed envelope is provided for the return of the deceased person's passport.
- Local services that may be of assistance to bereaved people are signposted.

69. Registrars also issue certified copies of the entry in the death register (sometimes called death certificates) which are useful for the administration of the person's estate. Copies of these certificates can be provided at a later stage on application by the relatives.

70. Once a death is registered, the registrar will notify a range of agencies in order to ensure that pensions are stopped, council tax bills are not sent to the deceased etc. These notifications will continue during a pandemic, although there may be some delays in comparison with normal service.

The process for bereaved people

71. Consideration should be given to the needs of those who have been bereaved. In the event of a death at home, it is likely that the relatives of the deceased person may contact their general practice (if they have one). The practice will need to know whether they should refer the caller to the PCT/LHB/trust, or whether they can take the relevant details and inform either the medical practitioner assigned to their practice for this purpose or the PCT/LHB/trust.

72. Every endeavour should be made to deal sensitively with bereaved people and to make processes as simple as possible for them. Consideration should be given in the LRF, prior to a pandemic, to support for bereaved people. Faith communities and bereavement and other support organisations and groups may be able to provide particular assistance in this regard. The Home Office guidance for planners preparing to manage deaths in a pandemic highlights the importance of involving such communities, organisations and groups in local planning networks.

Processes during a pandemic

73. PCTs/LHBs/trusts will need to consider the most appropriate arrangement for deploying the additional medical practitioners available to them, in the light of their local circumstances and the numbers available. There may be several alternatives, for example:

- assigning medical practitioners to cover deaths of patients belonging to one or more local practices
- assigning medical practitioners to deaths as they arise from a central point in the PCT/LHB/trust.

74. Normally, relatives will collect the MCCD from the hospital or from primary care premises and take it to the registrar. Where an MCCD is provided under the different ways of working, it will be given directly to the family. During a pandemic, relatives may be concerned about collecting/delivering, or be unable (for example, due to personal ill health or ill health of other family members) to collect/deliver, the MCCD or they may be asked not to attend in person (see paragraph 65). In such circumstances, it would be acceptable for the MCCD to be faxed or emailed to the registrar to enable death registration/issue of certificate for burial or cremation to proceed. Medical practitioners providing the MCCD should be prepared to fax or email the MCCD to the registrar if the relatives are not able to take forward matters in a timely manner. Relatives will then

need to collect the MCCD at a later stage. However, medical practitioners should be able to discuss with the family the benefits of attendance, whether at that time or subsequently, at the local register office. The requirement that deaths be registered in the first five days after death remains unchanged.

75. Proformas used in assessment of the cause of death (see paragraph 33 above) will need to be incorporated into the deceased's medical record in case the cause of death is questioned at a later stage. Where a medical practitioner is assigned to particular practices, it may be simplest for the proformas to be returned to the practices for filing. Where the practitioner is assigned to deaths by the PCT/LHB/trust, the proformas should be returned to the PCT/LHB/trust and arrangements made for them to be returned to the practices concerned in an appropriate manner (for example, in batches).

Infection control

76. Influenza can be transferred to hands from hard surfaces for up to 24 hours after the surface has been contaminated, and from soft materials (pyjamas, magazines, tissues) for up to two hours after, although in very low quantities after 15 minutes. When medical practitioners assess a patient for the purposes of death certification they should follow good infection control practice and in particular wash their hands (or use an alcohol handrub) at the end of the visit.

77. If other members of the household have pandemic influenza there is a risk of droplet spread from people who are coughing or sneezing. If it is possible to complete an appropriate assessment without interviewing such persons this would be preferable (assuming that the potential informant is well enough to be interviewed). Otherwise, the medical practitioner should follow good infection control practice, including appropriate protective masks.

78. Guidance on infection control in the occupational setting during an influenza pandemic and on risk assessments is available from the Department of Health and the Health & Safety Executive.

Business continuity

79. Medical practitioners who have volunteered to assist during a pandemic and other staff involved in death and cremation certification processes, including registrars, will also be vulnerable to pandemic influenza. It is important that this is taken into account in the business continuity plans of all the organisations concerned.

Central coordination during a pandemic

80. There should be a contact point in the PCT/LHB/trust that can be used for enquiries (other than those to the coroner) about death certification in a pandemic.

Deaths in custody

81. Deaths in custody arouse particular concern, as those concerned are in the care of the state. Additional safeguards may be applied in such cases. Rules require that the death of a person in a prison, detention centre or young offender establishment, or held under rules relating to detention in the Armed Forces, must be reported to the coroner. Where a death occurs in prison, an inquest with a jury must be held, even when the death was from natural causes.

82. Where a person is detained in other circumstances (for example under mental health legislation), reporting to the coroner is only necessary in the circumstances set out in Appendix B (for example, if the death is due to suicide). However, in practice natural deaths occurring in particular settings (such as high security mental health services) may also be reported.

83. Experience from previous pandemics has shown that attack rates in closed establishments may be very high. It may not be feasible to hold inquests and the extent of enquiries that canbe made may be more limited than usual. It will be possible for inquests to be opened and adjourned, and authority provided for disposal by the coroner if appropriate.

84. The Ministry of Justice is developing guidance for coroners and coronial services during a pandemic, which will include alternative ways of working to reduce the pressure on the service.

85. When a person dies in custody the body should be inspected externally by a registered medical practitioner independent of the custodial body (for example, not one of the prison's medical practitioners) and enquiries should be made by that practitioner to ensure that there are no suspicious circumstances surrounding the death. The medical practitioner should consider whether there is documentary evidence of the deceased having influenza-like or other serious physical illness that could cause death. The registered medical practitioner will provide the MCCD, Referral to the coroner will be needed and a post-mortem may be required.

86. PCTs/LHBs/trusts that commission prison healthcare need to plan well in advance appropriate arrangements for independent medical practitioner(s) who can assess deaths within the relevant establishments. If the location of the establishment is relatively remote, particular attention to business continuity may be needed, as medical practitioners will also be vulnerable to pandemic influenza. Attention should also be given to the resources needed by practitioners for certification (notably books of MCCDs). It may be useful for planning to take place in conjunction with the relevant PCT/LHB/trust.

Communications

87. Changes to the processes for death and cremation certification require particularly careful communication. In the event that changes are needed, in addition to the need for general understanding of why it is necessary to change processes, sensitive communication with bereaved people (who may have wished to see their usual general practitioner after a bereavement) is also vital.

88. The Home Office guidance *Planning for a possible influenza pandemic: A framework for planners preparing to manage deaths* offers further guidance on communications. In particular, it notes that local communications will be the first step in providing reassurance. The emphasis should be **tell it all, tell it truthfully and tell it quickly**. PCTs/LHBs/trusts will need to ensure that issues concerning death and cremation certification are included when developing their communications plans prior to a pandemic.

Recovery

89. The UK Influenza Pandemic Preparedness Strategy (Nov 2011) adopts a new UK approach to the indicators for action in a future pandemic response. This takes the form of a series of phases, named: Detection, Assessment, Treatment, Escalation and Recovery and incorporates indicators for moving from one phase to another. The phases are not numbered as they are not linear, may not follow in strict order, and it is possible to move back and forth or jump phases. The indicator for moving into the recovery phases would be when influenza activity is either significantly reduced compared to its peak or when the activity is considered to be within acceptable parameters. The focus of this stage will include the restoration of business as usual services. At some point the emergency powers enabling the GMC to restore doctors temporarily to the register will end – employers should ensure that doctors holding temporary registration cease practise once the emergency ends.

Appendix A – Overview of the current system for death and cremation certification

1. Currently, medical practitioners have a duty under the Births and Deaths Registration Act 1953 to complete a medical certificate of cause of death (MCCD) if they attended the deceased during their last illness. The contents of the MCCD comply with World Health Organization (WHO) recommendations to ensure comparability for epidemiological purposes. The information recorded on the MCCD includes the name and age of the deceased, the date and place of death, when they were last seen alive by the certifying doctor, the cause of death and whether it may have been contributed to by the employment of the deceased at some time, and whether the certified cause of death takes account of post-mortem findings.

2. The MCCD is delivered by the informant (usually the next of kin) to the registrar of births and deaths, who issues the death certificate. The registrar is also under a statutory duty to refer certain cases to the coroner.

3. The registrar has a duty to refer deaths to the coroner if:

   - either, the deceased had not been seen by the certifying doctor within 14 days of the death,
   - or, the certifying doctor had not seen the body after death.

4. Registrars are also required to refer deaths to coroners where:

   - the cause of death is unknown
   - the death was violent or unnatural or suspicious
   - the death may be due to an accident (whenever it occurred)
   - the death may be due to self-neglect or neglect by others
   - the death may be due to an industrial disease or related to the deceased's employment
   - the death may be due to an abortion
   - the death occurred during an operation or before recovery from the effects of an anaesthetic
   - the death may be a suicide

- the death occurred during or shortly after detention in police or prison custody.

5. In practice, medical practitioners themselves tend to refer cases directly to the coroner where there is uncertainty about the cause of death or reason to believe that the death was suspicious, or if the death might fall into one of the categories reportable under the registration legislation. The guidance notes on the MCCD remind medical practitioners of the above categories.

6. Assuming neither the doctor nor the registrar refers the case to the coroner, the registrar issues a green certificate for burial or cremation. The family can then proceed with a burial.

7. In addition, for cremation, a separate application is made to the crematorium on the statutory **Application for Cremation (known as form Cremation 1)** – usually by the deceased's executor or next of kin. The applicant has to provide details including their relationship to the deceased; the place, time and date of death; whether there may be any reason to suspect violence, poison or neglect; whether there is any reason to think an examination of the remains is desirable; and details of the patient's general medical practitioner. This form is passed to the relevant crematorium.[8]

8. For cremation there is also a requirement for a **Medical Certificate (form Cremation 4)** which is completed by a registered medical practitioner. This medical practitioner can be the same one who completed the MCCD (and in practice often is). Questions on this form include:

- How long did the doctor attend the deceased?
- When was the deceased last seen alive?
- When was the body seen?
- What, if any, examination was made of the body?
- What were the cause and mode of death?
- Were any surgical interventions made within a year before death?
- Is there any reason to suspect poison, violence or neglect?
- Is there any reason to suppose that a further examination is necessary?

9. This is generally the main opportunity for information on implants to be registered.

[8] Following modernisation this form will be known as Form 1.

10. This form is then passed to another medical practitioner, who will complete the confirmatory certificate described below (form Cremation 5).

11. The **Confirmatory Medical Certificate (form Cremation 5)** must be completed by a different medical practitioner, who must not be a relative of the deceased or a relative or partner of the doctor who completed the Medical Certificate (form Cremation 4) and who has been registered with the General Medical Council (GMC) for at least five years, although European qualifications may also permit a registered doctor to sign this form. The Confirmatory Medical Certificate, in addition to an expectation that the practitioner has examined form Cremation 4, asks:

- Have you seen the body of the deceased?
- Have you carefully examined the body externally?
- Have you seen and questioned the medical practitioner who gave the above certificate (ie form Cremation 4)?
- Have you seen and questioned any other medical practitioner who attended the deceased? (If so, give details.)
- Have you seen and questioned any person who nursed the deceased during the last illness, or who was present at the death (give details and say if seen alone)?
- Have you seen and questioned any other person (give details and state if seen alone)?

12. The declaration confirms that the doctor knows of no reasonable cause to suspect that the deceased died either a violent or unnatural or sudden death of which the cause is unknown, or died in such a place or circumstances as to require an inquest. The form is sent to a medical referee (another fully registered doctor of five years' standing, and appointed by the Ministry of Justice on the nomination of the cremation authority duly meeting the fees payable to the referee).

13. The **Authorisation of Cremation of Deceased Person by Medical Referee (Form Cremation 10)** is completed by the medical referee, authorising the superintendent of the crematorium to cremate the remains. The medical referee may make any enquiries thought appropriate of other signatories, and may refuse cremation unless a post-mortem is carried out.

Appendix B - Certification and registration of deaths in the UK

	England and Wales	Scotland	Northern Ireland
1. Requirements for death certification	i. The registered medical practitioner who attended the deceased during their last illness has a statutory duty to certify the cause of death on the prescribed form and deliver it to the registrar. ii. The Medical Certificate of Cause of Death is prescribed in regulations made by the Registrar General.	i. The registered medical practitioner who attended the deceased during their last illness has a statutory duty to certify the cause of death on the prescribed form and give it to the informant or to the district registrar (where no medical practitioner was in attendance, or where s/he is unable to provide a medical certificate, then any medical practitioner who is able to do so may certify). ii. As in England and Wales.	i. The registered medical practitioner who treated the deceased within the last 28 days prior to the date of death has a statutory duty to certify the cause of death on the prescribed form and give it to the informant. ii. As in England and Wales.
2. Reporting deaths to the coroner/procurator fiscal	Registrars have a duty to refer deaths to the coroner in the circumstances prescribed in the regulations (see list of circumstances at Annex 1).	Registrars have a duty to report certain deaths to the procurator fiscal (see Annex 3 below). In addition, the certifying doctor has a duty to report such deaths, so the procurator fiscal will normally receive a report from both the registrar and the certifying doctor.	Registrars have a duty to refer the death to the coroner in circumstances set out in the Coroners Act (Northern Ireland) 1959 Section 7 (see Annex 2 below).
3. Registration of deaths	i. A registrar must register a death when s/he receives the	i. A registrar must register a death when s/he receives	As in England and Wales.

	information required to be registered about the deceased and about the cause of death. ii. A registrar may not register a death that has been reported to the coroner without authority from the coroner to do so. iii. A death is registered without a qualified informant where the coroner has held (or in certain circumstances, opened) an inquest and supplies the death registration information to the registrar. iv. Cause of death can be certified to the registrar: - by a registered medical practitioner (see 1) - by the coroner following post-mortem - by the coroner on inquest or inquest adjourned. Where no medical practitioner who attended the deceased before death is available to certify the cause of death, the death is reported to the coroner. Information about cause of death may be made available from medical records by a doctor	information required to be registered about the deceased and about the cause of death. ii. Any death registered by a registrar where a Medical Certificate of Cause of Death was not produced by the informant at the time of registration, and has not subsequently been produced by a registered medical practitioner, must be reported by the registrar to the procurator fiscal as an uncertified death. iii. A death can be registered without a qualified informant on the authority of the Registrar General, provided s/he is satisfied that the correct particulars concerning the death are available. iv. Cause of death can be certified to the registrar: - by a registered medical practitioner (including a pathologist) - by the procurator fiscal or to the - Registrar General by the procurator fiscal following investigation and/or post-mortem examination (the Registrar General may register the	

	who could not sign the death certificate. If the coroner is satisfied that there is no need for a post-mortem or inquest, the death is registered showing the cause of death given by the coroner or the informant as 'uncertified'.	death, or amend or correct the information recorded, including the cause of death).	

Annex 1 – Reference to the coroner in England and Wales

Registration of Births and Deaths Regulations 1987

41 Reference to coroner

(1) Where the relevant registrar is informed of the death of any person he shall, subject to paragraph (2), report the death to the coroner on an approved form if the death is one –

(a) in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or

(b) in respect of which the registrar –

(i) has been unable to obtain a duly completed certificate of cause of death, or

(ii) has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise, that the deceased was seen by the certifying medical practitioner neither after death nor within 14 days before death; or

(c) the cause of which appears to be unknown; or

(d) which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or

(e) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or

(f) which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning.

(2) Where the registrar has reason to believe, with respect to any death of which he is informed or in respect of which a certificate of cause of death has been delivered to him, that the circumstances of the death were such that it is the duty of some person or authority other than himself to report the death to the coroner, he shall either satisfy himself that it has been reported or report it himself.

(3) The registrar shall not register any death –

(a) which he has himself reported to the coroner;

(b) which to his knowledge it is the duty of any other person or authority to report to the coroner; or

(c) which to his knowledge has been reported to the coroner, until he has received either a coroner's certificate after inquest or a notification from the coroner that he does not intend to hold an inquest.

Annex 2 – Reference to the coroner in Northern Ireland

Coroners Act (Northern Ireland) 1959

7. Every medical practitioner, registrar of deaths or funeral director and every occupier of a house or mobile dwelling and every person in charge of any institution or premises in which a deceased person was residing, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within 28 days prior to his death, or in circumstances as may require investigation (including death as a result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of such deceased person is of the facts and circumstances relating to the death.

Annex 3 – Reference to the procurator fiscal in Scotland

Scottish Registrars Handbook of Instructions

D13 Certain deaths to be reported to the procurator fiscal – see guidance for doctors at http://www.copfs.gov.uk/publications/1998/11/deathandthepf

The procurator fiscal has a duty to investigate certain deaths. Generally the procurator fiscal will enquire into any sudden, suspicious, accidental, unexpected and unexplained death. However the procurator fiscal may enquire into any death brought to his or her notice if he or she thinks it necessary to do so. In particular, the procurator fiscal will want to know from the registrars of any death where the circumstances or evidence suggest that the death may fall into one or more of the following categories:

- any death due to violent, suspicious or unexplained cause;
- any death related to occupation, for example industrial disease or poisoning;
- any death involving fault or neglect on the part of another;
- any death as a result of abortion or attempted abortion;
- possible or suspected suicide;
- any death as a result of medical mishap; and any death where a complaint is received which suggests that medical treatment or the absence of treatment may have contributed to the death;
- any death resulting from an accident;
- any death arising out of the use of a vehicle including an aircraft, ship or train;
- any death due to poisoning or suspected poisoning, including by prescription or non-prescription drugs, other substances, gas or solvent fumes;
- any death by drowning;
- any death by burning or scalding, or as a result of a fire or explosion;
- any death due to a notifiable infectious disease, or food poisoning;
- certain deaths of children – any death of a newborn child whose body is found, any sudden death in infancy, any death due to suffocation including overlaying, any death of a foster child;
- any death in legal custody;
- any death of a person of residence unknown, who died other than in a house;

- any death at work, whether or not as a result of an accident;
- any death where a doctor has been unable to certify a cause.

Appendix C - Cremation requirements in the UK

	England and Wales	Scotland	Northern Ireland
1. Requirements for cremation	As set out in the Cremation Regulations 2008: i. The applicant (usually next of kin or executor) must sign a completed application form which must be countersigned by a householder who knows the applicant. ii. The registered medical practitioner who attended the deceased during their last illness and who can certify definitely as to the cause of death is expected to complete a form providing details of the circumstances in which the deceased died. iii. A second medical practitioner, independent of the first, and of at least five years standing, completes a confirmatory certificate after examining the body and form made under ii. above and discussing the case with the medical practitioner who	As set out in the Cremation Regulations (Scotland) 1935 as amended: i. The applicant (usually next of kin or executor) must sign a completed application form which must be countersigned by a householder who knows the applicant. ii. The registered medical practitioner who attended the deceased during their last illness (or if no one was in attendance the ordinary medical attendant of the deceased) and who can certify definitely as to the cause of death is expected to complete a form providing details of the circumstances in which the deceased died. iii. A second medical practitioner, independent of the first, and of at least five years standing, completes a confirmatory	As set out in the Cremation (Belfast) Regulations 1961: i. The applicant (usually next of kin or executor) must sign a completed application form which must be countersigned by a Justice of the Peace. ii. The registered medical practitioner who attended the deceased during their last illness and who can certify definitely as to the cause of death is expected to complete a form providing details of the circumstances in which the deceased died. iii. A second medical practitioner, independent of the first and who must not have attended the deceased in any way, and of at least five years standing, completes a confirmatory certificate after examining the body and form made under ii. above and discussing the case

	attended the deceased during their last illness. iv. A third medical practitioner known as the medical referee[10] who is of five years standing and has suitable experience and has been appointed by the Secretary of State, has signed a form authorising cremation. v. Forms substantially to the like effect if the person died in Scotland, Northern Ireland or the Islands. vi. Registration requirements are set out below.	certificate and form made under ii. above and discussing the case with the medical practitioner who attended the deceased during their last illness. iv. A third medical practitioner known as the medical referee'° who is of five years standing and has suitable experience and has been appointed by the Secretary of State, has signed a form authorising cremation. v. Forms substantially to the like effect if the person died in England, as well as either the coroner's Out of England Order or the coroner's cremation certificate. vi. Forms substantially to the like effect elsewhere further outside of Scotland or, in their absence, the Secretary of State may grant authority to the medical referee to cremate.	with the medical practitioner who attended the deceased during their last illness. iv. A third medical practitioner known as the medical referee'° who is of five years standing and has suitable experience and has been appointed by the Secretary of State, has signed a form authorising cremation. v. Forms substantially to the like effect if the person died in Scotland, England, Wales or the islands and an Out of Country order signed by a coroner in England, Wales and Northern Ireland or procurator fiscal in Scotland. vi. Registration requirements are set out below. vii. It is not lawful to cremate where the deceased has left written direction to the contrary or where remains are unidentified.
2. Involvement of the coroner/ procurator fiscal	If the coroner has ordered a post-mortem examination or opened an inquest, or the death occurred abroad, the medical element of the above procedure does not	If the procurator fiscal has ordered a post-mortem examination or opened a Fatal Accident Inquiry (FAI) the medical element of the above procedure does not	If the coroner has ordered a post-mortem examination or opened an inquest, or an investigation has been made under Section 11(1) of the Coroners Act

	apply - instead the coroner completes a certificate and the medical referee authorises cremation (and an application form is still required).	apply - instead the procurator fiscal completes an E1 Form and the medical referee authorises cremation (and an application form is still required).	(Northern Ireland) 1959, the medical element of the above procedure does not apply - instead the coroner completes a certificate and the medical referee authorises cremation (and an application form is still required).
3. Registration of deaths matters	i. The medical referee must be satisfied that the registrar has issued a certificate under Section 240) of the Births and Deaths Registration Act 1953 before authorising cremation, ii. or that the coroner has issued his/her certificate, iii. or that the death occurred outside England and Wales and a certificate of non-liability under Section 24(2) of the Births and Deaths Registration Act 1953 has been issued/coroner has issued his/her certificate. iv. The crematorium must also keep its own register of cremations.	i. The medical referee must be satisfied that a certificate has been produced in the form of Schedule 14 of The Registration of Births, Still-births, Deaths and Marriages (Prescription of Forms) (Scotland) Regulations 1997 before authorising cremation, ii. or that the procurator fiscal has issued his/her E1 Form, iii. or that the death has been registered in Northern Ireland. iv. The crematorium must also keep its own register of cremations.	i. The medical referee must be satisfied that the registrar has registered a death before authorising cremation, ii. or that the coroner has issued his/her certificate, iii. or that the death was registered in Scotland, iv. or that a coroner in England or Wales has issued an Out of Country order. v. If death occurred abroad, ie outside the UK or Northern Ireland, documents should be verified by the British Ambassador. vi. The crematorium must also keep its own register of cremations.

[10] NB the medical referee may complete the confirmatory medical certificate in an emergency only

Appendix D – Draft proforma to assist death certification

This proforma would be adapted if necessary to take into account the symptoms resulting from the pandemic influenza virus.

Information concerning a person who has not been seen by a medical practitioner in the 28 days before death

Information collected by (name)

(post)

on (date)

Name of deceased:

Date of birth:

Home address (including postcode):

Name and address of General practitioner :

1. Source(s) of information (indicate name of informants):

   GP Yes/No

   Hospital Yes/No

   Health professional Yes/No

   Family and friends Yes/No

2. Did the person personally or did someone on their behalf make contact with the National Flu Line service? Yes/No

3. Immediately prior to death, did the person show symptoms of:

   Fever? Yes/No

Cough? Yes/No

Headache? Yes/No

Coryzal symptoms/viral respiratory infection? Yes/No

Myalgia? Yes/No

Sore throat? Yes/No

For children Rhinorrhoea? Yes/No

For infants Diarrhoea and vomiting? Yes/No

For older children Pharyngitis? Yes/No

4. Have PCR/tracheal swabs confirmed possible flu? Yes/No

5. Is there evidence in the home of the deceased having taken anti-viral therapy for influenza? Yes/No

6. Any other information relevant to the cause of death.

Appendix E – Checklists for planning

Actions for medical practitioners

Now and up to WHO Phase 5

- Retiring or retired medical practitioners who would be prepared to assist with certifying deaths in a pandemic should register with the BMA database of retired and non-practising medical practitioners who are prepared to assist in a pandemic[9] or, if they prefer, notify their local PCT/LHB.
- Retiring or retired medical practitioners who would be prepared to assist in a pandemic by acting as crematorium medical referees should register with the BMA database or their local cremation authority
- Medical practitioners who are neither retired nor in active medical practice (for example those on a career break) and who would be prepared to assist in a pandemic in either of the above activities should take the same action.
- Medical practitioners who have indicated that they are willing to assist in these ways should, where necessary, undertake any relevant training offered by the PCT/LHB/trust/cremation authority.

At WHO Phase 5

- Medical practitioners willing to assist in a pandemic who have not yet indicated their willingness to assist to the PCT/LHB/trust/cremation authority should do so.
- Medical practitioners should ensure that they are registered with the GMC and should re-register if necessary.
- Medical practitioners should ensure that the PCT/LHB/trust/cremation authority has all their relevant contact details (in particular mobile phone numbers) and should undertake any relevant training offered by the PCT/LHB/trust/cremation authority.
- Where medical practitioners have agreed to assist in death certification, they should ensure that they understand how they will be informed of deaths, that they know the location to which proformas used in assessment should be returned, and that they have the necessary resources (eg books of medical certificates of cause of death (MCCDs), face masks).

[9] www.bma.org.uk

During the pandemic

- Medical practitioners who have agreed to assist in a pandemic should be attentive to announcements concerning the development of the pandemic. Once the pandemic has reached the UK (World Health Organization (WHO) Phase 6, UK alert level 2) it is expected to spread rapidly throughout the country.
- Additional medical practitioners should prepare for deployment and collect the resources they may need from the pre-agreed point.
- Proformas used in assessment should be returned in a timely manner to the pre-agreed point.

During recovery

- At the end of the pandemic wave, all unused resources, including books of MCCDs, should be returned to the agreed point.
- Further pandemic waves may follow weeks to months after the first wave. Practitioners should confirm that they would be willing to assist in a further wave.

Actions for PCTs/LHBs/trusts

Now and up to WHO Phase 5

- Develop a list of medical practitioners willing to assist in a pandemic, including information on contact details and GMC registration status.
- If there is concern that insufficient medical practitioners will be available, discuss the situation with neighbouring PCTs/LHBs/trusts to establish the potential for mutual aid.
- Make a provisional plan for the deployment of additional medical practitioners (eg whether they should be linked to specific primary care practices or deployed centrally by the PCT/LHB/trust).
- Take account of the need for face masks for those providing death and cremation certification when assessing needs for face masks in the PCT/LHB/trust.
- Ensure that medical practitioners who carry out death and cremation certification have access to appropriate training in the correct completion of the relevant forms, and encourage them to participate in audit of standards of completion of certification.
- Ensure that medical practitioners who may assist in death and cremation certification during a pandemic have access to training on certification and infection control.

- In association with partners from **social care services**, **ambulance services** and **primary care services**, ensure that there will be sufficient numbers of people who can verify death (for example in a nursing home) and, where necessary, ensure that training (for example for nurses) is provided to increase the numbers of people who can fulfil this role.
- Contact the **local register office** to discuss arrangements for obtaining books of MCCDs, timescales for delivery etc.
- Establish with the **local register office** whether MCCDs could be faxed or emailed to the local register office during a pandemic, and test possible transmission routes.
- Ensure that issues concerning death and cremation certification are included in communications plans.
- Working with **authorities responsible for custodial establishments**, ensure that appropriate plans are in place so that the bodies of persons who die in custody can be examined by an independent medical practitioner, and that the plans cover how to obtain the resources needed by those practitioners for certification (eg books of MCCDs).

At WHO Phase 5

- Contact medical practitioners on your list as soon as possible, and confirm that they are willing and able to assist; check their contact details and registration status and ask them to re-register with the GMC if necessary; check whether any updating training is required and, if so, arrange its provision.
- Assess whether sufficient medical practitioners will be available or whether a neighbouring PCT/LHB/trust needs to be contacted regarding mutual aid.
- Provide medical practitioners with an appropriate contract for terms and conditions of service and ensure that they have appropriate indemnity (see *Pandemic influenza: Human resources guidance for the NHS*).
- Ensure that all resources needed for completion of the certification processes, and booklets on what to do after a death, are available.
- Finalise the plan for deployment of additional medical practitioners and ensure that they are aware of it and of how to obtain the resources needed for certification (eg to be collected from a central point at the PCT/LHB/trust or from elsewhere).
- If the PCT/LHB/trust is to deploy medical practitioners centrally, ensure that appropriate arrangements are made for this (those managing the deployment must have the contact details of the medical practitioners etc) – this may be done through the central contact point.

- Ensure that all **primary care practices** are aware of the plan and of the action that should be taken if a bereaved person contacts the practice seeking death certification.
- Ensure that **primary care practices** are aware of the possibility of alternative ways of working
- Ensure that arrangements are in place for a central contact point for enquiries about death and cremation certification during a pandemic.
- Notify the **local register office** of the names and medical qualifications of additional medical practitioners who will be working in the area, and details of the central contact point for enquiries.
- Working with **authorities responsible for custodial establishments**, ensure that medical practitioners are contacted and plans for assessing deaths in custody during a pandemic are confirmed. Ensure that appropriate resources will be available and that the medical practitioners know how to access them.

During the pandemic

- Ensure that arrangements for the central contact point are maintained.
- If the PCT/LHB/trust is to deploy additional medical practitioners itself, ensure that arrangements for this work smoothly.
- If assessment proformas are returned directly to the PCT/LHB/trust, ensure that these are batched and sent to the relevant **primary care practices** for filing in as timely a manner as possible.

Actions for primary care services

Now and up to WHO Phase 5

- Ensure that medical practitioners who carry out death and cremation certification receive appropriate training in the correct completion of the forms, and that standards of certification are subject to appropriate audit.
- Assess whether normal supplies of MCCDs would be sufficient in a pandemic and, if not, plan to increase supply.

At WHO Phase 5

- Be aware of the plan for deployment of additional medical practitioners and of the action that should be taken if a bereaved person contacts the practice seeking death certification.
- Ensure that all staff who may receive such enquiries (eg reception staff) are aware of the action to be taken.

- Ensure that an adequate supply of MCCDs is available for primary care practitioners.

During a pandemic

- Ensure that assessment proformas are filed in the notes of deceased patients.

Actions for secondary care services

Now and up to WHO Phase 5

- Ensure that medical practitioners who carry out death and cremation certification receive appropriate training in the correct completion of the forms, and that standards of certification are subject to appropriate audit.
- Assess whether normal supplies of MCCDs would be sufficient in a pandemic and, if not, plan to increase supply.
- Establish with the **local register office** whether MCCDs could be faxed or emailed to the local register office during a pandemic, and test possible transmission routes.

At WHO Phase 5

- Re-test transmission routes for MCCDs with the **local register office**.
- Ensure adequate supply of MCCDs and streamlined form Cremation 4s

During a pandemic

- Ensure that death and cremation certification is carried out in a timely manner.

Actions for cremation authorities

Now and up to WHO Phase 5

- Develop a list of medical practitioners willing to act as medical referees during a pandemic, including information on contact details and GMC registration status (practitioners must be of at least five years' standing).
- Ensure that, under normal circumstances, more than one deputy medical referee is available per crematorium, and increase the number available prior to a pandemic. Be ready to make applications for approval to the Ministry of Justice no later than **WHO Phase 4**.
- Ensure that additional medical referees are approved by the Ministry of Justice and that they possess the standard guidance for medical referees.

- Establish with the **local register office** whether disposal documents could be faxed or emailed to the cremation authority during a pandemic, and test possible transmission routes.

At WHO Phase 5

- Contact medical practitioners on your list, and confirm that they are willing to act and are aware of practical arrangements for performing their role (eg location etc). Medical referees who have been approved by the Ministry of Justice are able to perform this role from that time onwards and, therefore, can be deployed as the cremation authority sees fit.
- Re-test transmission routes for disposal documents with the **local register office**.

Actions for the Local Resilience Forum

Now and up to WHO Phase 5

- Ensure that appropriate procedures are in place so that the Local Resilience Forum (LRF) will have the information it needs to decide whether to implement alternative ways of working.
- Ensure that death and cremation certification is covered in communications plans.

During the pandemic (as Strategic Co-ordinating Group)

- Be aware of national announcements of any legal amendments that have been made to facilitate alternative death and cremation certification processes.
- Keep local circumstances under review
- If alternative processes are implemented, ensure that all those who may need to be aware of this are informed (eg **PCT/LHB/trust**, **secondary care services**, **cremation authority**, **coroner**, **local register office**) and that the changes are appropriately reflected in wider communications plans.

Actions for authorities responsible for custodial establishments

Now and up to WHO Phase 5

- Working with the **PCT/LHB/trust**, ensure that appropriate plans are in place to ensure that the bodies of persons who die in custody can be examined by an independent medical practitioner, and that the plans cover how to obtain the resources needed by those practitioners for certification (eg books of MCCDs,).
- Working with the **PCT/LHB/trust**, ensure that medical practitioners are contacted and plans for assessing deaths in custody during a pandemic are confirmed. Ensure that appropriate resources will be available and that the medical practitioners know how to access them.

During the pandemic

- Work closely with the **SCG** to consider whether alternative ways of working should be implemented.
- In the event of implementation, ensure the smooth working of assessment by independent medical practitioners.

Action for all organisations

- Ensure that business continuity plans take into account the need for death and cremation certification, both in preparing for and during a pandemic.