Summary of Death Certification

The information provided in this form is confidential

This form must be completed by the attending doctor independently to the review by the medical examiner. Section 2 must be completed so that a record of the attending doctor’s view on the primary cause of death is recorded to ensure transparency of the process.

1. Name of deceased person and the date and time of death

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date and time of death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Forename)</td>
<td>(Date)</td>
</tr>
<tr>
<td>(Family name)</td>
<td>(Time)</td>
</tr>
</tbody>
</table>

2. Synopsis of circumstances, medical history and preliminary view of the cause of death

This information is to provide information to support your proposed cause of death or referral to the coroner. Please include information regarding any concerns raised.

Do you have any concerns about the quality of care this patient received?  Yes  No  

(If no preliminary view can be formed make a note of the reason.)  

Approximate interval between onset and death

<table>
<thead>
<tr>
<th>1a</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1b</td>
<td></td>
</tr>
<tr>
<td>1c</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
This form may be used and evaluated by pilot areas working with the Department of Health to improve the process of death certification.

NHS/Hospital No.: _________________

Reference No.: ___ / ___ / ___

(To be completed by medical examiner’s office.)

3. Advice from medical examiner, coroner or their respective officers (if applicable)

Spoken with: ___________________________ Date and time: ___ / ___ / ___ at __________

Notes:

Outcome:

6. Doctor’s decision and action

☐ I feel able to complete the MCCD with no need for coroner referral (Only valid for a doctor that attended the deceased.)

☐ I feel this case requires referral to the coroner for further action for the following reason ________________________________

A Medical Certificate of Cause of Death (MCCD) must not be issued for registration purposes until the cause of death has been formally confirmed by a medical examiner.

7. Medical practitioner’s name and contact details

Full name (print): ___________________________ GMC No.: _________________

Location/department: _____________________________________________________________

Personal phone/bleep No.: ___________________________ Alternative/out-of-hours contact No.: ___________________________

Signature: __________________________________________ Date: ___ / ___ / ___

(The doctor providing the information in this form needs to be available to respond, if asked, to any enquiries from a medical examiner or officer.)