The Royal College of Pathologists
Pathology: the science behind the cure

Cause of death list

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Contents

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Foreword

Achieving accuracy of Medical Certificates of Cause of Death is vital to the health of the nation and is core to medical examiner work. The Cause of death list has an important part to play, also helping remind which deaths must be notified to a senior coroner. Publication enables all involved; registrars, doctors, coroners and coroners' officers to speak from the same page. This is very welcome, and I am delighted the Royal College of Pathologists brings medical expertise leading the Cause of Death List to greater prominence.

Dr Alan Fletcher
National Medical Examiner

Introduction

The Royal College of Pathologists is the lead medical royal college for medical examiners, providing training, guidance and continuing professional development for this important new medical specialty. Medical examiners will scrutinise all deaths not reported to the coroner, ensuring appropriate coronial referral and accurate certification and speaking to bereaved families, in particular answering any questions they might have.

The College has worked closely with the Department of Health and Social Care, National Medical Examiner, Chief Coroner, General Register Office (GRO), medical royal colleges and patient and faith groups to support implementation of the medical examiner system, initially in acute trusts and shared services partnerships and then to cover all deaths in England and Wales. The College is grateful to these stakeholders for their contribution to updating this important document and their support of medical examiner implementation in general. We hope that this guide will be helpful for doctors completing death certificates, medical examiners supporting them and registrars registering deaths, ultimately for the benefit of the bereaved.

This Cause of death list replaces the 2016 document issued to registrars by the GRO and intentionally retains the same name and format as that document. It is not intended to be an exhaustive list of all possible causes of death, but deals with conditions that have previously prompted discussion between certifying doctors, registrars and coroners. It includes clarification about common conditions, such as pneumonia and heart failure, and less common ones, such as ankylostomiasis and spirochaetal jaundice. The list has grown organically and reflects previous areas of contention rather than a systematic approach. This version seeks to provide consistent guidance for all stakeholders, removing ambiguity and improving consistency. The College will be responsible for updating the content as required and welcomes feedback.

The document offers guidance for those completing death certificates and those registering deaths. In the current non-statutory medical examiner system, registrars will continue to refer deaths to the coroner in line with the Notification of Deaths Regulations 2019.

The Cause of death list details some of the conditions that may be included on the Medical Certificate of Cause of Death (MCCD). The MCCD is completed by the certifying doctor in line with current legislation, which can be found at: www.gov.uk/government/publications/guidance-notes-for-completing-a-medical-certificate-of-cause-of-death

This document is being published during the emergency legislation of the Coronavirus Act 2020. Under the Act, several processes relating to the certification and registration of death have changed temporarily. The changes to the process of death certification do not affect the acceptable causes of death that can be registered without coronial referral. This guidance will remain current after the Coronavirus Act 2020 has been repealed.

Registrars

Registrars should use this guide in the first instance if they have a query about the acceptability of a cause of death.

If a query is not covered in this guide, or if you have additional concerns, please call the GRO on 0300 123 1837 (select option 2).

To provide feedback on this document, please contact the Royal College of Pathologists.

Referral to the coroner

The Notifications of Deaths Regulations came into force in October 2019. These made it a legal requirement for certain deaths to be reported to the coroner. Briefly, a registered medical practitioner has a duty to notify the coroner if any of the following circumstances apply:

- poisoning
- exposure to a toxic substance
- use of a medicinal product, controlled drug or psychoactive substance
- violence
- trauma or injury
- self-harm
- neglect, including self-neglect
- the person undergoing a 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
- the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances above
- the cause of death is unknown
- the person died in custody
- there is no attending medical practitioner to sign the death certificate
- the deceased cannot be identified.

The regulations can be accessed at: www.legislation.gov.uk/uksi/2019/1112/made

The Ministry of Justice has issued guidance to medical practitioners on the Notifications of Deaths Regulations:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851972/registered-medical-practitioners-notification-deaths-regulations-guidance.pdf

Notes on the cause of death list

Key considerations for registrars of births and deaths

This list is not exhaustive and needs to be used in conjunction with the Registrars Handbook, particularly D2 and D4. The fact that a cause if death does not appear in this list does not necessarily mean that it is, or is not, acceptable.

Each MCCD should be looked at on its own merits and consideration should be given to all conditions recorded on the certificate and the order in which they are recorded.

The Medical Certificate of Cause of Death

The certifying doctor will complete an MCCD. It is the registrar's legal responsibility to report certain deaths to the coroner. Information about which deaths need referring to the coroner are at D2 and D4 of the Registrar's Handbook. Consideration should also be given to the expected statutory provisions by medical practitioners.

The cause of death must be copied precisely from the MCCD – the registrar cannot amend the cause of death and cannot correct any spelling mistakes. Please take care when completing the MCCD and write clearly. If the death needs to be referred to the coroner, the registrar should refer without discussing the cause with the certifying doctor. Under the current non-statutory scheme, there is no obligation for the registrar to discuss the cause of death with a medical examiner. If in doubt, the medical examiner may wish to discuss the acceptability of a cause of death with their local registrar.

Information in the Medical Certificate of Cause of Death

Please note: This section is intended to provide a broad understanding of the type of information shown in a MCCD. It is not intended to provide definitive definitions or guidance.

The MCCD is divided into two parts, the functions of which are described in more detail below. When considering the information in Parts I and II, registrars should be alert to whether modes of death have been recorded and whether a given cause of death appears to be unnatural.

Part I
This is the sequence of causes, conditions or events directly leading to the death and is split into three parts: a, b and c. There must be an acceptable cause of death in Part I (either in a, b or c). A condition which is not acceptable as a casue on its own may become acceptable when accompanised by another condition. However, an acceptable condition does **not** remain acceptable if another cause of death in a, b, or c requires referral to the coroner.

Part II
Causes in Part II are other significant conditions contributing to the death, but not directly related to the disease or the condition causing it.

If there is not an acceptable cause of death in Part I, an acceptable cause of death in Part II does **not** mean a registration can be concluded.

Even if there are acceptable causes of death in Part I, Part II can still lead to referral to the coroner, if it suggests the death might have been unnatural (please see list below).

Remember: Part II cannot make Part I better but it can make it worse.

Modes of dying
A 'mode' of dying is one which does not explain 'why'. For example, 'coma' does not explain the underlying condition leading to death. Examples of modes of death (not a complete list) include:

- cardiac arrest
- coma
- exhaustion
- renal/kidney failure
- respiratory arrest

- syncope.

Terms such as ‘acute’, ‘chronic’, ‘acute on chronic’ or ‘multiple’ do not turn modes of dying into acceptable causes.

The exception to this rule is ‘heart failure’, which is acceptable on its own, although ideally further supporting information should be provided.

It is acceptable for a mode of dying to be supported/explained by an acceptable disease or condition beneath it in Part I.

The terms ‘possible’, ‘probable’ and ‘suspected’ should not be used on the MCCD.

‘Unnatural’ causes of death
If there appears to be an unnatural cause of death in either Part I or II, the death must be referred to the coroner.

Referral to the coroner
Deaths should be referred to the coroner in the usual way for your office.

Infections
The name of the organism responsible for an infection should be included on the MCCD where known.

Malignancies
The specific type of malignancy should be included where known, e.g. squamous cell carcinoma of the bronchus, rather than lung cancer.

Use of abbreviations
Abbreviations must not be used on the MCCD (but can be used on the counterfoil).

Unknown
In general, the term ‘unknown’ should be avoided on the MCCD. However, it is acceptable in certain circumstances, such as metastatic malignancy of unknown primary, and septicaemia/sepsis of unknown aetiology.

Possible/probable
‘Possible’ and ‘probable’ should not be used on the MCCD. The certifying doctor states the cause of death to the best of their knowledge and belief. If they do not know the cause of death, they must notify the coroner.

Industrial disease
Some conditions are commonly associated with occupational exposure to hazardous substances. Mesothelioma, for example, is often due to occupational exposure to asbestos. In such conditions, the death must be referred to the coroner unless the doctor states that the disease was non-industrial or non-occupational. There are also some diseases that are occasionally related to the deceased’s occupation, such as lung cancer or emphysema, but which also occur commonly in the general population. In these conditions, the doctor completing the MCCD should check carefully that they were not related to an occupation, but does not need to state ‘non-occupational’ on the MCCD. If the condition may have been related to the deceased’s occupation, the case must be referred to the coroner.

Definition of terms

Acceptable – This cause of death does not need to be referred to the coroner, however if it is used in conjunction with another cause that does need to be referred, the death should still be referred to the coroner.

Some causes of death are acceptable only if further information is provided, for example:

- acceptable if noted to be spontaneous
- acceptable if supported by another acceptable cause of death
- acceptable over a certain age.

Mode of dying – refer to coroner unless supported by an acceptable cause of death. A mode of dying has to be supported by another cause of death which is acceptable in Part I of the MCCD.

Refer to coroner unless doctor states non-industrial – doctor should write ‘non-industrial’ after the cause. The informant should **not** be asked whether the condition was caused by the deceased’s occupation.

Refer to coroner – death needs to be referred to the coroner wherever this condition appears on the MCCD, regardless of any other conditions recorded or where on the MCCD it is written.

Refer to coroner if not accompanied by another acceptable condition – the acceptable condition must be in part 1.

Causes of death

A

Cause of death	Action
Abdominal aortic aneurysm	Acceptable
Acute alcoholism	Refer to coroner
Acute dehydration	Refer to coroner
Acute left/right ventricular failure	Acceptable
Acute aortic syndrome	Acceptable
Acute respiratory distress syndrome	Refer to coroner unless supported by another acceptable condition
Adult respiratory distress syndrome	Refer to coroner unless supported by another acceptable condition
Advancing years – old age	Acceptable if deceased was aged 80 or over
Acquired Immunodeficiency Syndrome	Acceptable, unless the informant or MCCD states due to contaminated blood products or needles drugs etc.; do not ask question – only if this information is volunteered
Alcohol abuse	Acceptable if long standing (chronic), refer to coroner if sudden (acute)
Alzheimer's disease	Acceptable
Anaemia	Acceptable if deceased is over 70 years old (it should be possible to give an underlying cause or at least categorise it as e.g. iron deficiency or megaloblastic); refer to coroner if deceased is under 70 years old and not supported by another acceptable condition
Anaphylaxis	Refer to coroner
Ankylostomiasis	Refer to coroner unless doctor states non-industrial
Angiosarcoma of the liver	Refer to coroner unless doctor states non-industrial
Anorexia nervosa	Acceptable
Anthracosis, Anthracosilicosis	Refer to coroner unless doctor states non-industrial
Anthrax	Refer to coroner unless doctor states non-industrial

Cause of death	Action
Arrhythmia/Cardiac arrhythmia	Refer to coroner unless supported by an acceptable cause of death
Arteriosclerosis/Atherosclerosis	Acceptable
Asbestosis	Refer to coroner unless doctor states non-industrial
Aspergillosis	Acceptable
Asphyxia	Refer to coroner
Aspiration pneumonia	Refer to coroner unless supported by an acceptable cause of death
Asystole	Refer to coroner unless supported by an acceptable cause of death
Atrial fibrillation	Acceptable

B

Cause of death	Action
Bacterial meningitis	Acceptable
Bagassosis	Refer to coroner unless doctor states non-industrial
Barotrauma	Refer to coroner
Berylliosis	Refer to coroner unless doctor states non-industrial
Biliary (biliary tract) infection/sepsis	Acceptable
Bilateral pleural thickening	Refer to coroner unless doctor states non-industrial
Birth asphyxia	Refer to coroner
Birth injury	Refer to coroner
Biventricular failure	Acceptable
Bladder – Cancer of the bladder or renal pelvis or urethra or ureter	Refer to coroner if deceased's occupation took them into contact with industrial chemical or dyestuff preparations or process; otherwise acceptable
Bleeding peptic ulcer	Acceptable
Blood Poisoning/septicaemia	Refer to coroner if on its own or in association with an injury

Cause of death	Action
Bone marrow failure	Refer to coroner unless supported by an acceptable cause of death, e.g. myelodysplasia or old age
Bowel obstruction	Acceptable if qualified as spontaneous or with an acceptable underlying cause
Brain failure	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Bronchial or bronchus cancer	Refer to coroner if deceased's occupation took them into contact with nickel fumes or vapour or associated with fibre board or wooden goods; otherwise acceptable
Bronchopneumonia	Acceptable
Bronchospasm	Refer to coroner if not supported by another acceptable condition
Brucella/Brucellosis	Refer to coroner unless doctor states non-industrial
Byssinosis	Refer to coroner unless doctor states non-industrial

C

Cause of death	Action
Cachexia	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Caisson disease	Refer to coroner
Cancer of the bladder or renal pelvis or urethra or ureter	Refer to coroner if deceased's occupation took them into contact with industrial chemical or dyestuff preparations or process; otherwise acceptable
Cancer of the lung/bronchus	Refer to coroner if deceased's occupation took them into contact with nickel fumes, vapour or associated with fibre board or wooden goods; otherwise acceptable
Cancer of the nose/nasopharynx/nasal sinuses	Refer to coroner if deceased's occupation took them into contact with nickel fumes, vapour or associated with fibre board or wooden goods; otherwise acceptable
Cancer of the skin/squamous-cell carcinoma	Refer to coroner if deceased's occupation took them in contact with tar, mineral, oil, pitch, bitumen, soot, etc.; otherwise acceptable

Cause of death	Action
Cardiac arrest	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Cardiac tamponade	Refer to corner unless supported by an acceptable cause of death
Cardiogenic shock	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Cardiorespiratory arrest	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Cardiovascular accident/event/incident	Refer to coroner unless supported by an acceptable cause of death
Cellulitis	Acceptable
Cerebral/intracerebral haemorrhage	Not acceptable on its own unless it is qualified as spontaneous* or primary; otherwise needs an acceptable underlying disease as it can be caused by trauma
Cerebral palsy	Refer to coroner (may be as result of birth injury)
Cerebellar ataxia	Acceptable
Cerebrovascular accident/event/haemorrhage	Acceptable (but 'accident' should be avoided if possible)
Chest infection	Acceptable
Cholecystitis	Acceptable
Chronic airflow limitation	Refer to coroner if deceased's occupation was an underground coal miner; otherwise acceptable
Chronic bronchitis	Refer to coroner if deceased's occupation was an underground coal miner; otherwise acceptable
Chronic obstructive airways disease (COAD)	Refer to coroner if deceased's occupation was an underground coal miner; otherwise acceptable
Chronic obstructive pulmonary disease (COPD)	Refer to coroner if deceased's occupation was an underground coal miner; otherwise acceptable
Chronic alcoholism†	Acceptable
Circulatory failure	Mode of dying – refer to coroner unless supported by an acceptable cause of death

* A spontaneous cerebral haemorrhage is natural and the same as a haemorrhagic stroke.
† Or Alcohol dependence syndrome.

Cause of death	Action
Circulatory collapse	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Clostridium difficile	Acceptable
Coma	Mode of dying – refer to coroner unless supported by an acceptable cause of death
Compressed air illness	Refer to coroner
Congenital	Acceptable as a generic term qualifying a condition at any age
Congenital ventricular septal defect	Acceptable
Congestive cardiac failure	Acceptable
Congestive heart failure	Acceptable
Coronavirus infection/disease	Acceptable
Cot death	Refer to coroner
COVID-19	Acceptable
COVID-19 infection/pneumonia	Acceptable
Creutzfeldt Jakob disease	Acceptable
Cryptogenic* fibrosing alveolitis	Refer to coroner

D

Cause of death	Action
Debility	Mode of dying – refer to the coroner unless supported by an acceptable cause of death
Debility of old age	Acceptable provided the deceased is 80 or over; otherwise refer to coroner
Dehydration	Refer to coroner
Dementia	Acceptable
Depression	Not acceptable as a standalone cause of death

* Also Idiopathic

Cause of death	Action
Diabetes mellitus	Acceptable
Diabetic foot gangrene	Acceptable
Dissection of thoracic aorta/aortic aneurysm	Acceptable
Diver's palsy, Diver's paralysis	Refer to coroner
Diverticulitis/diverticular abscess	Acceptable
Digoxin toxicity	Refer to coroner if in Part I
Duodenal ulcer	Not acceptable as a standalone cause of death but acceptable if supporting, e.g. upper gastrointestinal haemorrhage
Dust reticulation	Refer to coroner unless doctor states non-industrial
Dysbarism	Refer to coroner unless doctor states non-industrial

E

Cause of death	Action
Escherichia coli (E-coli)	Refer to coroner if not supported by another acceptable condition
Escherichia coli (E-coli) septicaemia	Acceptable
Electromechanical dissociation	Refer to coroner if not supported by another acceptable condition
Emphysema	Refer to coroner if deceased's occupation was a coal miner/worker exposed to dust for more than 20 years; otherwise acceptable
Empyema	Acceptable
Encephalitis	Acceptable
Exhaustion	Mode of dying – Refer to coroner unless supported by an acceptable cause of death
Extreme prematurity	Acceptable
Extrinsic allergic alveolitis	Refer to coroner unless doctor states non-industrial

F

Cause of death	Action
Farmer's lung	Acceptable
Fibrosing alveolitis*	Refer to coroner if deceased's occupation brought them in to contact with dust; otherwise acceptable
Fracture	Refer to coroner unless doctor states that it was caused by a disease (e.g. osteoporosis)
Fracture – pathological	Acceptable if underlying disease stated
Frailty of old age	Acceptable provided the deceased is 80 or over, otherwise refer to coroner
Frailty syndrome	Refer to corner unless supported by an acceptable cause of death

G

Cause of death	Action
Gangrene	Refer to coroner if not supported by a circulatory disease
Gastric aspiration/aspiration of gastric contents	Refer to coroner if not supported by another acceptable condition
Gastroenteritis	Acceptable
Gastrointestinal bleed/haemorrhage	Refer to coroner unless stated to be spontaneous
General debility	Mode of dying – refer to coroner if not supported by an underlying condition
General system failure	Refer to coroner if not supported by another acceptable condition
Goodpasture's syndrome/Anti Glomerular Basement Membrane disease	Acceptable
Gram negative septicaemia	Refer to coroner unless supported by an acceptable cause of death
Grinder's asthma	Refer to coroner
Grinder's phthisis	Refer to coroner

* Insertion of the word Idiopathic will reassure not industrial or drug-related

H

Cause of death	Action
Haematemesis	Refer to coroner if not supported by another acceptable condition
Haemothorax	Refer to coroner
Haemorrhagic shock	Refer to coroner if not supported by another acceptable condition
Hartmann's procedure	Refer to coroner
Heart attack	Refer to coroner
Heart Block (Complete or Möbitz Type 2)	Acceptable (See arrhythmia)
Heart failure	Acceptable
Hepatic failure	Refer to coroner if not supported by another acceptable condition
Hepatitis	Refer to coroner if deceased was a health or care worker; otherwise acceptable
Hepatitis Australian antigen	Refer to coroner if deceased was a health or care worker; otherwise acceptable
Hepatitis B	Refer to coroner if deceased was a health or care worker; otherwise acceptable
Hepatitis viral	Refer to coroner if deceased was a health or care worker; otherwise acceptable
Hepatorenal failure	Refer to coroner if not supported by another acceptable condition
Hernia	Acceptable, if described anatomically and supporting another acceptable cause of death (e.g. intestinal obstruction/peritonitis); refer to coroner if incisional/parastomal (may be related to surgical procedure)
Huntington's chorea/disease	Acceptable
Hydrocephalus	Refer to corner unless supported by an acceptable cause of death (or state congenital)
Hypertension	Not acceptable as a standalone cause of death but acceptable if supporting, e.g. intracerebral haemorrhage
Hyperthermia	Refer to coroner

Cause of death	Action
Hypothermia	Refer to coroner
Hypovolaemia/hypovolaemic shock	Refer to coroner, unless supported by an acceptable cause of death
Hypoxic brain injury	Refer to coroner unless supported by an acceptable cause of death

I

Cause of death	Action
Iatrogenic	Refer to coroner if anywhere on the MCCD
Inanition	Refer to coroner unless supported by an acceptable cause of death
Inflammatory bowel disease	Acceptable
Infective endocarditis	Acceptable
Influenza	Acceptable
Injury*	Refer to coroner
Intestinal bleeding/haemorrhage	Refer to coroner unless supported by an acceptable cause of death
Intestinal ischaemia	Acceptable
Intestinal obstruction	Refer to coroner unless supported by an acceptable cause of death (or spontaneous)
Intracerebral haemorrhage (duplication with cerebral)	Refer to coroner unless supported by an acceptable cause of death (or spontaneous/primary)
Intracranial haemorrhage (duplication with cerebral)	Refer to coroner unless supported by an acceptable cause of death (or spontaneous/primary)
Intraoral squamous-cell carcinoma	Refer to coroner if deceased's occupation brought them in to contact with tar; otherwise acceptable
Ischaemic heart disease	Acceptable
Ischaemic bowel	Acceptable

* Unless as acute kidney injury supported by an acceptable underlying cause of death.

J

Cause of death	Action
Jaundice	Refer to coroner unless qualified by an acceptable underlying cause of death

K

Cause of death	Action
Kidney failure/injury	Refer to coroner if not supported by another acceptable condition
Kidney stones	Acceptable

L

Cause of death	Action
Leaking aortic aneurysm	Acceptable
Left ventricular failure	Acceptable
Leptospira canicola	Refer to coroner unless doctor states non-industrial
Leptospira icterohaemorrhagiae	Refer to coroner unless doctor states non-industrial
Learning disability/difficulties	Not acceptable as a standalone cause of death; this non-medical term should be avoided where possible
Lewy body dementia	Acceptable
Linitis plastica	Acceptable
Liver failure	Refer to coroner if not supported by another acceptable condition
Lower respiratory tract infection	Acceptable
Lung cancer (cancer of the lung, bronchus or bronchial)	Refer to coroner if deceased's occupation brought them into contact with nickel fumes or vapour or associated with fibreboard or wooden goods; otherwise acceptable
(Systemic) lupus erythematosus	Acceptable
Lymphoproliferative disorder/disease	Acceptable

M

Cause of death	Action
Malignant disease (cancer or sarcoma or leukaemia or anaemia)	Refer to coroner if deceased's occupation brought them into contact with X-rays or radioactive substances or radiation; acceptable if qualified as of unknown primary
Malnutrition	Refer to coroner
Medical techniques	Refer to coroner
Meningitis	Acceptable
Meningococcal meningitis	Acceptable
Meningococcal septicaemia	Acceptable
Mesothelioma	Refer to coroner unless doctor states non-industrial
Motor neurone disease	Acceptable
Meticillin Resistant Staphylococcus Aureus (MRSA)	Refer to coroner if not supported by another acceptable condition
Meticillin Resistant Staphylococcus Aureus (MRSA) septicaemia	Refer to coroner if not supported by another acceptable condition
Mycobacterium avium intracellulare infection	Acceptable
Multiple sclerosis	Acceptable
Multiple organ failure	Refer to coroner if not supported by another acceptable condition
Multiple system atrophy	Acceptable
Multiple organ failure/multiple organ dysfunction syndrome	Refer to coroner if not supported by another acceptable condition
Myelodysplasia	Acceptable
Myeloma	Acceptable
Myeloproliferative disorder	Acceptable
Myocardial infarction or degeneration	Acceptable

N

Cause of death	Action
Natural causes	This is not a cause of death and is not acceptable anywhere on the MCCD
Nephrotic syndrome	Acceptable
Neurodegenerative disease of unknown cause	Acceptable
Neutropaenic sepsis	Refer to coroner if not supported by another acceptable condition
Non-cirrhotic portal fibrosis	Refer to coroner if not supported by another acceptable condition
Norovirus	Acceptable

O

Cause of death	Action
Occipital lobe infarction	Acceptable
Old age	Acceptable provided the deceased is 80 or over, otherwise refer to coroner
On chronic renal failure*	Refer to coroner if not supported by another acceptable condition
Osteomyelitis	Acceptable
Osteonecrosis	Refer to coroner unless doctor states non-industrial

P

Cause of death	Action
Pancreatitis	Acceptable
Parkinsonism, Parkinson's Disease	Acceptable
Pathological fracture	Acceptable provided cause is included and is natural

* Chronic kidney disease is acceptable.

Cause of death	Action
Peptic ulcer	Not acceptable as a standalone cause of death but acceptable if supporting, e.g. upper gastrointestinal haemorrhage
Perforated (perforation of the) bowel/intestine*	Refer to coroner unless supported by an acceptable cause of death (or spontaneous)
Perforated intra-abdominal viscus†	Refer to coroner unless supported by an acceptable cause of death (or spontaneous)
Perinatal asphyxia	Acceptable for a neonatal death
Peripheral vascular disease	Acceptable
Peritonitis	Acceptable
Pleural mesothelioma	Refer to coroner unless doctor states non-industrial
Pneumococcal septicaemia	Acceptable
Pneumoconiosis	Refer to coroner unless doctor states non-industrial
Pneumothorax	Refer to coroner unless supported by an acceptable cause of death (or spontaneous)
Pseudo-obstruction (of the intestine)	Acceptable
Pulmonary embolism	Acceptable
Pulmonary tuberculosis	Acceptable unless certificate states industrial

R

Cause of death	Action
Radiation colitis	Refer to coroner
Refusal to eat	Refer to coroner
Renal failure	Refer to coroner unless supported by an acceptable cause of death
Renal/kidney injury‡	Refer to coroner unless supported by an acceptable cause of death

* Prefixed with ‘spontaneous’ is acceptable.
† Prefixed with ‘spontaneous’ is acceptable.
‡ This refers to abnormal renal function, not traumatic injury.

Cause of death	Action
Respiratory arrest or failure	Mode of dying – refer to coroner unless supported by an acceptable cause
Rheumatic heart disease	Acceptable
Rheumatoid arthritis	Acceptable
Right ventricular failure	Acceptable
Ruptured abdominal aortic aneurysm	Acceptable

S

Cause of death	Action
SARS-CoV-2 infection	Acceptable
Schizophrenia/psychosis	Refer to coroner unless supporting an acceptable cause of death
Senile dementia	Acceptable if deceased was aged 80 or over. Refer to coroner if deceased under 80 years old and not supported by another acceptable condition
Senility	Acceptable if deceased was aged 80 or over
Sepsis	Refer to coroner unless supported by an acceptable cause of death
Sepsis of unknown aetiology	Acceptable
Septic arthritis	Acceptable
Septic shock	Refer to coroner unless supported by an acceptable cause of death
Septicaemia	Refer to coroner unless supported by an acceptable cause of death (or unknown aetiology)
Siderosis	Refer to coroner unless doctor states non-industrial
Silicosis	Refer to coroner unless doctor states non-industrial
Smoking	Refer to coroner if not supporting another acceptable condition
Spinal cord ischaemia	Acceptable
Spirochaetal jaundice	Refer to coroner unless doctor states non-industrial

Cause of death	Action
Spontaneous gastrointestinal bleed/haemorrhage	Acceptable
Spontaneous intracerebral haemorrhage	Acceptable
Staphylococcus (aureus)	Refer to coroner if not supported by another acceptable condition
Steele Richardson syndrome	Acceptable
Streptococcal septicaemia	Acceptable (See meningococcal septicaemia)
Streptococcus	Refer to coroner unless supported by an acceptable cause of death
Streptococcus suis	Refer to coroner unless doctor states non-industrial
Stroke	Acceptable provided deceased is not a child
Spontaneous subarachnoid haemorrhage	Acceptable
Stent/stented	Refer to coroner
Subdural haematoma	Refer to coroner
Sudden infant death syndrome	Refer to coroner if not supported by another acceptable condition
Syncope	Mode of death - Refer to coroner if not supported by another acceptable condition
(Systemic) mixed connective tissue disorder	Acceptable

T

Cause of death	Action
Tetanus	Refer to coroner
Toxic anaemia	Refer to coroner
Toxic jaundice	Refer to coroner
Toxicity	Refer to coroner
Tuberculosis	Refer to coroner unless doctor states non-industrial

U

Cause of death	Action
Ulcer duodenal/gastric/peptic	Not acceptable as a standalone cause of death but acceptable if supporting, e.g. upper gastrointestinal haemorrhage
Unknown	Refer to coroner unless cause of death given is a malignant disease or septicaemia where the site/cause is unknown.
Uraemia	Refer to coroner if not supported by another acceptable condition
Urinary tract infection	Acceptable
Urosepsis	Acceptable

V

Cause of death	Action
Vagal inhibition	Refer to coroner if not supported by another acceptable condition
Vascular dementia	Acceptable
Ventricular failure	Acceptable
Viral hepatitis	Refer to coroner unless doctor states non-industrial

W

Cause of death	Action
Weil's disease	Refer to coroner unless doctor states non-industrial