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

National Medical Examiner's Good Practice Series No. 21

Implantable medical devices on attending practitioner MCCDs

June 2025

Author: Dr Alan Fletcher, National Medical Examiner

Contents

The Royal College of Pathologists
6 Alie Street
London E1 8QT
T: 020 7451 6700
F: 020 7451 6701
www.rcpath.org
Registered charity in England and Wales, no. 261035

About the National Medical Examiner's Good Practice Series

Medical examiners are senior doctors providing independent scrutiny of non-coronial deaths in England and Wales; a statutory requirement since 9 September 2024.

While there is extensive guidance available on a wide range of topics for NHS and public sector staff, the National Medical Examiner's Good Practice Series highlights how medical examiners and medical examiner officers can better meet the needs of local communities and work more effectively with colleagues and partners.

The Good Practice Series is a topical collection of focused summary documents, designed to be easily read and digested by busy front-line staff, with links to further reading, guidance and support.

Introduction

An implantable medical device is a device that is placed or surgically inserted into the body, either permanently or temporarily to support functions or specific organs or tissues, monitor physiological activities or deliver medicines.

Guidance for medical practitioners completing Medical Certificates of Cause of Death[1] (MCCDs) notes that some implantable medical devices – referred to as hazardous implants – may damage cremation equipment and/or cause harm to crematorium staff or the environment if not removed from the body of the deceased before cremation. Attending practitioners are responsible for providing information about hazardous implantable medical devices on attending practitioner MCCDs (AP MCCDs) used in the overwhelming majority of cases.[2] It is important that all involved in the death certification process understand their responsibilities concerning hazardous implantable medical devices.

Information about hazardous implantable medical devices may come to light after the attending practitioner has completed the AP MCCD. Depending on when this occurs, this can cause difficulties for funeral directors and crematorium staff, including medical referees. Bereaved families may be adversely affected and funeral plans may be delayed, causing additional distress.

This paper explores how medical examiners and local partners can work together to minimise distress and delays to bereaved people. Medical examiner offices are often well-placed to support and, where appropriate, coordinate discussions between local agencies. However, medical examiners have statutory responsibilities and do not oversee end-to-end death certification and registration processes. These require cooperative working across a range of agencies; all local partners and stakeholders need to work together constructively to ensure bereaved people receive the best possible support.

---

[1] Department of Health & Social Care. Guidance for medical practitioners completing medical certificates of cause of death in England and Wales. Available at: https://www.gov.uk/government/publications/medical-certificate-of-cause-of-death-mccd-guidance-for-medical-practitioners/guidance-for-medical-practitioners-completing-medical-certificates-of-cause-of-death-in-england-and-wales

[2] As noted in MCCD guidance, the overwhelming majority of medical certificates are completed by attending practitioners. In exceptional circumstances where there is no attending practitioner, there is provision for coroners to refer deaths for completion of medical examiner MCCDs, in which all information including that relating to medical devices is completed by medical examiners. This good practice clarifies responsibilities for completing only AP MCCDs which cover the certification process in almost all cases.

Recommendations for medical examiners

Medical examiners should:

- note that it is the attending practitioner's responsibility (not the medical examiner) to determine whether there is a hazardous implantable medical device in AP MCCDs and that guidance requires attending practitioners to identify only hazardous devices. Enquiries about implantable medical devices should be directed to responsible attending practitioners not medical examiner offices
- note that registrars now provide information to crematorium staff including medical referees about medical devices using green form 9 – Part D (see Appendix 1)
- when evidence emerges during scrutiny that a hazardous implantable device may be present, bring this to the attention of the attending practitioner who is responsible for providing this information before the AP MCCD is sent to the register office, as omissions and errors can result in delays to funerals and risks for crematorium equipment or staff
- when a death referred to the medical examiner office is to be notified to the coroner, include in the referral any information the attending practitioner has provided about implantable medical devices to enable the coroner to forward this information as appropriate (for example when completing form Cremation 6)
- support local stakeholders, partners and systems when they take measures to improve provision of accurate information about hazardous implantable medical devices by attending practitioners. However, medical examiner offices must prioritise their statutory duties and cannot divert resources to fill information gaps for others in individual cases, such as searching for attending practitioners' contact details
- note that medical examiners do not have a legal basis to access patient records unless they are providing independent scrutiny of causes of death and, therefore, cannot search medical records in other circumstances, for example when the coroner has provided the cause of death and sends the registrar forms CN2, 99, 120 and 121. Medical examiners should direct those seeking information about implantable medical devices to contact relevant attending practitioners.

Context and background

Correct information about hazardous implantable medical devices is important for cremations, as some devices present a risk if they are not removed before cremation. Risks include damaging the internal structures of the cremation equipment, generating expensive repair costs, and risks to the safety of the technical staff. Considerations should also be made for burials, as hazardous implants may have an environmental impact.

Besides the potential for damaging cremation equipment or causing harm to crematorium staff or the environment, incorrect or absent information about hazardous implantable medical devices in the AP MCCD can result in delays to funerals and, therefore, may cause unnecessary distress to bereaved people.

There have been changes in how information about implantable medical devices is made available to crematorium staff (see ‘After the AP MCCD is completed’). Changes introduced by the Death Certification Reforms include discontinuance of cremation form 4. Crematorium medical referees previously reviewed the information in form 4 before authorising cremations but must now rely on information provided by the registrar or coroner. The Ministry of Justice is considering the future role of medical referees and will provide further information in due course.

MCCD guidance

The Department of Health & Social Care (DHSC) publishes official guidance for medical practitioners completing MCCDs, which notes that potentially hazardous implantable medical devices include but are not limited to:

- pacemakers
- implantable cardioverter defibrillators
- cardiac resynchronisation therapy devices
- implantable loop recorders (sometimes called Reveal devices)
- ventricular assist devices:
  - left ventricular assist devices
  - right ventricular assist devices

  - biventricular assist devices
- implantable drug pumps including intrathecal pumps
- neurostimulators (including for pain and functional electrical stimulation)
- bone growth stimulators
- Fixion nails
- any other battery powered or pressurised implant
- radioactive implants used to treat tumours, such as metal wires, seeds or tubes
- radiopharmaceutical treatment (via injection)

The AP MCCD includes a section where the attending practitioner is required to provide information about implantable medical devices. This section was added when the Death Certification Reforms were introduced in September 2024. It should be noted that the AP MCCD form refers to 'implantable medical devices' but the MCCD guidance for medical practitioners completing MCCDs states that attending practitioners 'only need to state whether there is a ***hazardous*** implantable medical device in the body of the deceased person' (emphasis added).

Official guidance for medical practitioners completing MCCDs notes 'the attending practitioner must indicate if they believe a hazardous implantable medical device is inside the body'. If the attending practitioner believes this is the case, they will need to provide details of the device, its location and whether the device has been removed.

Medical examiners are responsible for providing independent scrutiny of deaths not investigated by a coroner, and their duties are set out in statute. Medical examiners must prioritise these statutory requirements and do not have the capacity to review medical records to identify cases where hazardous implantable medical devices are present and may have been missed from the MCCD. Guidance clearly sets out that the attending practitioner is responsible for completing the implantable medical devices section; questions about the information provided should be directed to the relevant attending practitioner.

During the medical examiner's routine scrutiny process, information may come to light suggesting a hazardous implantable device is present or is likely to be present, and has

not been identified by the attending practitioner on the MCCD. When this occurs, the medical examiner should share this information with the attending practitioner to ensure the information is correct. However, this does not alter official guidance that responsibility for correctly providing information about implantable medical devices lies with the attending practitioner, not the medical examiner.

After the AP MCCD is completed

Once the medical examiner provides their declaration that the causes of death are accurate to the best of their knowledge and belief, the AP MCCD is sent to register office. Following registration, the information on the AP MCCD about implantable medical devices is transferred to the certificate for burial or cremation (the green form). Prior to 9 September 2024, medical practitioners provided crematorium staff with information about devices on form Cremation 4. This was reviewed by crematorium medical referees and enabled crematorium staff and funeral directors to identify the medical practitioner who provided the information and included their address and contact details.

The form Cremation 1 (application for cremation of the body of a person who has died) is completed by the person who is applying for the cremation – this is usually completed by a near relative of the deceased, or the executor of the estate. Part 3 Q3 asks for the name and contact details of the attending practitioner, and Part 3 Q4, 5 and 6 ask about the presence of potentially hazardous devices and whether they have yet been removed.

When the form Cremation 4 was discontinued in September 2024, the General Register Office implemented a new form (Form 9 – Part D, see Appendix 1). Form 9 – Part D is completed by registrars using details on the AP MCCD and records whether medical devices are present and, if so, what they are and whether they have been removed. The form includes the name of the attending medical practitioner and the medical examiner, but does not reinforce official guidance that the attending practitioner is responsible for the information about implantable medical devices on the AP MCCD, and that the medical examiner is not. This has caused an increase in calls and messages from medical referees, funeral directors and crematorium staff contacting medical examiners with questions about implantable medical devices that should be directed to the attending practitioner who completed the AP MCCD. The National Medical Examiner has suggested amendments to Form 9 – Part D to reflect MCCD guidance that the attending practitioner is responsible for information about medical devices and to include more details, such as

GMC number to help crematorium staff and medical referees to identify the relevant attending practitioner.

It is likely that funeral directors have less information regarding which medical practitioner provided information about implantable medical devices than was the case before 9 September 2024; this may explain the increase in funeral directors contacting medical examiners about implantable medical devices. Funeral directors and crematorium medical referees should direct such enquiries to the attending practitioner, not the medical examiner office.

In most cases, the information provided by attending practitioners regarding implantable devices will be accurate. However, it is possible that information about a hazardous medical device may be detected after the AP MCCD has been completed and sent to the register office or after registration; it is possible information could be transcribed incorrectly in some part of the process. In such cases, it is important that local partners in the death certification and registration process work together constructively in the interests of bereaved people.

There is no requirement in guidance to provide a new or amended AP MCCD, or for the registrar to re-register the death or issue a new green form. A proportionate solution should be agreed to enable the funeral to proceed in a timely manner, avoiding unnecessary delay and distress to the bereaved. For example, an email from the attending practitioner stating that an implant was present (despite it not being recorded on the AP MCCD) and a document from the funeral director or mortuary staff confirming that the implant has been removed should reassure the crematorium medical referee that no implant remains in the body. Local processes and information should reinforce official guidance that attending practitioners are responsible for providing accurate information about hazardous implantable medical devices on AP MCCDs.

Coroner notification

Form Cremation 6 is issued by coroners. The section regarding hazardous implantable medical devices (D[iii]) includes a ‘Don’t Know’ option. Coroners are not responsible for investigating this information if it has not been provided to them.

As there is no indication of the name of the attending practitioner on the form Cremation 6, there has been an increase in queries – for example, from funeral directors – directed to

medical examiner offices, which are not responsible for capturing this information. Medical examiner offices only have a legal basis for accessing patient records in cases where they are providing independent scrutiny of causes of death under the Coroners and Justice Act 2009 Section 20. They are, therefore, unable to respond to requests to search medical records to determine whether an implantable medical device may be present.

Local partners managing death registration should all work together constructively in the interests of bereaved people to establish processes to minimise delays and distress when questions about implantable medical devices arise.

Find out more

- NHS England. National Medical Examiner's guidance for England and Wales. Available at: https://www.england.nhs.uk/publication/national-medical-examiners-guidance-for-england-and-wales/#death-certification-reform
- Ministry of Justice. Cremation (England and Wales) Regulations 2008: Guidance to applicants. Available at: https://assets.publishing.service.gov.uk/media/66eadf53ba4b4b3f945016a5/Cremation_guidance_to_applicants__web_.pdf
- Ministry of Justice. Cremations taking place in England and Wales: forms and guidance. Available at: https://www.gov.uk/government/collections/cremation-forms-and-guidance
- Department of Health & Social Care. Guidance for medical practitioners completing medical certificates of cause of death in England and Wales. Available at: https://www.gov.uk/government/publications/medical-certificate-of-cause-of-death-mccd-guidance-for-medical-practitioners/guidance-for-medical-practitioners-completing-medical-certificates-of-cause-of-death-in-england-and-wales
- General Register Office. Guidebook for The Clergy. Pp. 32 and 57. Available at: https://assets.publishing.service.gov.uk/media/66cf07cda7256f1cd83a89b0/A-Guide-for-the-Clergy-August-2024.pdf
- UK Government. What to do after someone dies. Available at: https://www.gov.uk/after-a-death?step-by-step-nav=4f1fe77d-f43b-4581-baf9-e2600e2a2b7a
- UK Government. The Medical Certificate of Cause of Death Regulations 2024. Available at: https://www.legislation.gov.uk/uksi/2024/492/contents

Appendix 1 Green form 9 – Part D

Completed by registrars using information on the Medical Certificate of Cause of Death.

Form 9 – Part D – English

Please complete the below and attach to the Form 9, Part B.

Information taken from medical certificate of cause of death.

Medical device information	
Was a hazardous implant placed in the body?	
Device Type:	
Has the device been removed?	
AP Name:	ME Name:

Acknowledgements

This document was drafted following circulation to and input from the following people. The National Medical Examiner is grateful to all for their participation and support:

- Dr Alan Fletcher – National Medical Examiner (Chair)
- Paul Allcock – Government Liaison Officer, Society of Allied & Independent Funeral Directors
- Mike Birkinshaw – CEO, Federation of Burial and Cremation Authorities
- Helen Briggs – Office Co-ordinator to the National Medical Examiner Office, NHS England
- Stuart Cella – Joint Deputy Head RG Advisory Unit, General Register Office for England and Wales
- Mathew Crawley – Chief Executive, Institute of Cemetery & Crematorium Management
- Nick Day – Policy and Programme Lead, National Medical Examiner System
- Julie Dunk – former Chief Executive, Institute of Cemetery & Crematorium Management
- Douglas Findlay – Patient safety partner
- Natalie Harris – Medical Devices and Death Certification Senior Policy Manager, Welsh Government
- Simon Hawkins – Senior Policy Adviser, Death Certification Reform, DHSC
- Jennifer Hunt – Joint Deputy Head RG Advisory Unit, General Register Office for England and Wales
- Nick Lambert – Policy Adviser, Death Certification Reform, DHSC
- Jane Lawrence – Policy Manager, Medical Examiner System, NHS England
- Dr Suzy Lishman – Senior Advisor on Medical Examiners, Royal College of Pathologists
- Laura Pankhurst – Head of Cremation & Burial, Ministry of Justice

- Eric Powell – Head of Registration Services, General Register Office for England and Wales
- Graham Prestwich – Patient safety partner
- Phil Ramsden – Policy Manager, Burials and Cremation Policy Team, Ministry of Justice
- Ian Rudkin – Council Member, The Cremation Society of Great Britain
- Golda Shelley Fraser – Regional Medical Examiner, SW and Chair of ME Committee, RCPath
- Terry Tennens – CEO, Society of Allied & Independent Funeral Directors
- Agata Zylewicz-O'Brien – Senior Policy Advisor, Ministry of Justice