GlobalResearch
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Removal of “Form 5 Cremation Certificate” for U.K. Deaths Relating to COVID-19. Under Britain’s “Coronavirus Act”

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The Wall Will Fall 5 October 2020

Region: Europe
Theme: Intelligence, Media Disinformation, Science and Medicine

As we head in to winter watch death statistic manipulation go into overdrive, check out this “Medical Practitioners” guidance on death provisions.

Did you know that the UK Government have removed Form 5 of the Cremation Certificate for deaths relating to Covid-19 under the Coronavirus Act which is the form that the relative who registers the death must be given as it enables them to see and query the death certificate before cremation.

So basically if your loved one dies of or with Covid19 they can have their death certified and cremation certified by the same medical practitioner and sent for cremation within hours and the government have removed your right to see or query that decision before the cremation takes place which in turn removes your right to request a coroners report or second opinion.

Why would they do this? And the removal notice of Form 5 doesn’t explain what the section that’s been removed is actually for. I had to search the internet for older cremation forms to find out what Form 5 was used for. That information was nowhere on the UK Government website.

The order in which the comorbidities are listed determines how the death appears in the statistics and if the patient just happens to test positive without symptoms then it should not be listed in the cause of death at all. Neither “of Covid19” or “with Covid19” should be used at all….. the scam is bigger than you know.

> “I think this is about keeping COVID deaths high enough to justify the continuation of mask and lockdown fascism.This will prevent a lot of autopsies and second opinions. Dr. Yeadon has recently been taking them to task for classifying so many people who died of their comorbidities as deaths from COVID-19. He keeps pointing out that, on autopsy, forensic pathologists are regularly determining these patients expired from heart disease, cancer, stroke, and so on.Will our newly weaponized and deputized rule authoritarians prevent us from bringing these monsters to justice for their crimes against humanity?” Darwin K Hoop

Please take time to read these documents as I tracked them all down and pieced them

together myself:

Form Cremation 1 – Application for cremation of remains of deceased person (replaced form Cremation 1 issued 2009)

11. This form is to be completed by the applicant for cremation. This should usually be a near relative or an executor. Reasons should be given on the form explaining why any person making the application is not the near relative or an executor. All the questions on this form must be answered and all parts of the form must be completed before it is passed to the crematorium. You should assist applicants in providing any information that is required

12. Question 10 asks about hazardous implants. The medical referee will need to check and compare the information provided in the application with the information provided in the medical certificates. After discussion with the applicant, you may also be able to provide information or confirm that the implant has been removed. You should be aware, however, that some implants can cause damage to machinery or human life. It is therefore essential to ensure that any information about implants and their removal is included on form Cremation 1. A list of implants that may cause problems during cremation is provided at Annex C.

13. Part 5 of the form deals with the applicant's right to inspect the medical certificates (forms Cremation 4 and Cremation 5) before the medical referee authorises cremation. We expect you to advise the applicant in neutral terms of their right to inspect the medical certificates, and neither to encourage nor deter applicants from exercising that right (a suggested form of words is set out at Annex A). You will not need to record an answer at Part 5 if the applicant does not wish to inspect the certificates and should leave Part 5 blank in these circumstances. This will also allow the applicant to change their mind should they decide they do wish to inspect the certificates before the funeral takes place. The crematorium should be notified immediately after the applicant decides they wish to inspect the certificates where they left Part 5 of the application form blank.

14. You should, however, be aware that in certain circumstances, the death may need to be referred to a coroner. The coroner may then order a post-mortem examination or open an inquest. In these circumstances there is no right of inspection as the coroner will complete form Cremation 6 and there are no medical certificates to inspect. You may wish to write "not applicable – death referred to coroner" in Part 5 for such cases.

15. You should ensure that forms Cremation 1, 4 and 5 are sent to the crematorium as soon as possible before the date of the funeral. This is to ensure that the funeral is not delayed in the event that the applicant wants to inspect the forms. However, in certain circumstances it may be that the applicant does not want to inspect the forms if he or she would like the funeral to take place as soon after death as possible.

16. There is no easy solution to reconciling the applicant's right of inspection with a timely funeral. Your main role is to ensure that the forms are completed as quickly as possible, to facilitate inspection, and – importantly – to keep in contact with all the parties concerned in the process.

17. Applicants should be made aware that where they have indicated they wish to inspect the medical certificates the crematorium will notify them when the certificates have

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Coronavirus Act – excess death provisions: information and guidance for medical practitioners

31 March 2020

The Coronavirus Act of Parliament gained Royal Assent on 25 March 2020, and the commencement order for the clauses relating to death certification and cremation forms was signed on 26 March 2020. Guidance and information on these clauses are set out below, along with previous COVID-19 advice issued on 10 March,* included here for completeness.

NHS England and NHS Improvement

1. Medical certificate of cause of death

Guidance on the medical certificate of cause of death (MCCD) is here.

a. Any medical practitioner with GMC registration can sign the MCCD, even if they did not attend the deceased during their last illness, if the following conditions are met:

   i. The medical practitioner who attended is unable to sign the MCCD or it is impractical for them to do so and,

   ii. the medical practitioner who proposes to sign the MCCD is able to state the cause of death to the best of their knowledge and belief, and

   iii. a medical practitioner has attended the deceased (including visual/video consultation) within 28 days before death, or viewed the body in person after death (including for verification).

   If another medical practitioner attended the deceased during their last illness or after death, the medical practitioner signing the MCCD should record the name and GMC number of the medical practitioner who attended the deceased during their last illness or after death at the 'last seen alive' section of the MCCD.

   In addition to (i) to (iii) above, if no medical practitioner attended the deceased in the 28 days before death[1] or after death, a medical practitioner can sign the MCCD if the following conditions are met:

   iv. The medical practitioner who proposes to sign the MCCD is able to state the cause of death to the best of their knowledge and belief, and

   v. the medical practitioner has obtained agreement from the coroner they can complete the MCCD.

   Medical practitioners working in the same practice/hospital should find this straightforward as they can access patient records. Reasons it is impractical for the attending medical practitioner to complete the MCCD might include: severe pressure on NHS services and the need to ensure medical practitioners with appropriate skills are available to treat patients; and/or medical practitioners becoming infected with COVID-19 and needing to self-isolate. During periods of excess deaths due to COVID-19, healthcare providers are encouraged to redeploy medical practitioners whose role does not usually include direct

[1] See 2(d) regarding registrars' duties where the deceased was not seen alive in the 28 days before death.

patient care, such as some medical examiners, to provide indirect support by working as dedicated certifiers, completing MCCDs to enable other medical practitioners to focus on providing patient care.

b. Medical practitioners are required to certify causes of death "to the best of their knowledge and belief". Without diagnostic proof, if appropriate and to avoid delay, medical practitioners can circle '2' in the MCCD ("*information from post-mortem may be available later*") or tick Box B on the reverse of the MCCD for ante-mortem investigations. For example, if before death the patient had symptoms typical of COVID-19 infection, but the test result has not been received, it would be satisfactory to give 'COVID-19' as the cause of death, tick Box B and then share the test result when it becomes available.

c. The period during which an attending medical practitioner completing an MCCD must have seen the deceased before death (the 'last seen alive' requirement) is extended from 14 days to 28 days before death. 'Seen' in this context includes consultation using video technology. However, it does not include consultation by telephone/audio only.

d. The MCCD can be scanned or photographed and sent from a secure email account to registrars as an attachment. We recommend electronic transfer of MCCDs is used as standard practice. We expect registrars to determine the appropriate email address – for example, a secure email account.

e. COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD.*

2. Registration

a. As noted in 1(d), MCCDs can be scanned or photographed and sent by email to registrars as an attachment. We recommend electronic transfer of MCCDs is used as standard practice to reduce unnecessary contact between individuals and to accelerate processes.

b. Where electronic transfer is not possible, and the next of kin/informant is following self-isolation procedures, please arrange for an alternative informant who has not been in self-isolation to collect the MCCD and deliver to the registrar for registration purposes.

c. An informant can be someone who was present at the death, a hospital official, someone who is 'in charge of a body', or a funeral director.

d. If the deceased was not seen in the 28 days before death or after death by a medical practitioner, the MCCD can be completed if the conditions in 1a(iv)-(v) are met, but the death will need to be notified to the coroner. Medical practitioners are encouraged to work

below.

4.1 Sequence leading to death, underlying cause and contributory causes

The MCCD is set out in two parts, in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD). You are asked to start with the immediate, direct cause of death on line Ia, then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence. If the certificate has been completed properly, the condition on the lowest completed line of part I will have caused all of the conditions on the lines above it. This initiating condition, on the lowest line of part I will usually be selected as the **underlying cause of death,** following the ICD coding rules. WHO defines the ***underlying cause of death*** as **"a) the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury". From a public health point of view, preventing this first disease or injury will result in the greatest health gain.** Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health service and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.

You should also enter any other diseases, injuries, conditions, or events that contributed to the death, but were not part of the direct sequence, in part two of the certificate. The conditions mentioned in part two must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time.

Examples of cause of death section from MCCDs (including example of COVID-19 as underlying cause of death):

	Cause of death ***the disease or condition thought to be the underlying cause should appear in the lowest completed line of part I***	
I	(a) *Disease or condition leading directly to death*	Interstitial pneumonitis
	(b) *other disease or condition, if any, leading to* I(a)	*COVID-19*
	(c) *other disease or condition, if any, leading to* I(b)	primary adenocarcinoma of ascending colon
II	*Other significant conditions* **Contributing to death** *but not related to the disease or condition causing it*	diabetes mellitus

	Cause of death ***the disease or condition thought to be the underlying cause should appear in the lowest completed line of part I***	
I	(a) *Disease or condition leading directly to death*	Intraperitoneal haemorrhage
	(b) other disease or condition, if any, leading to I(a)	Ruptured metastatic deposit in liver
	(c)other disease or condition, if any, leading to I(b)	primary adenocarcinoma of ascending colon
II.	*Other significant conditions* **Contributing to death** *but not related to the disease or condition causing it*	Non-insulin dependent diabetes

The colon cancer on line 1(c) led directly to the liver metastases on line 1(b), which ruptured, causing the fatal haemorrhage on 1(a). Adenocarcinoma of the colon is the underlying cause of death.

below.

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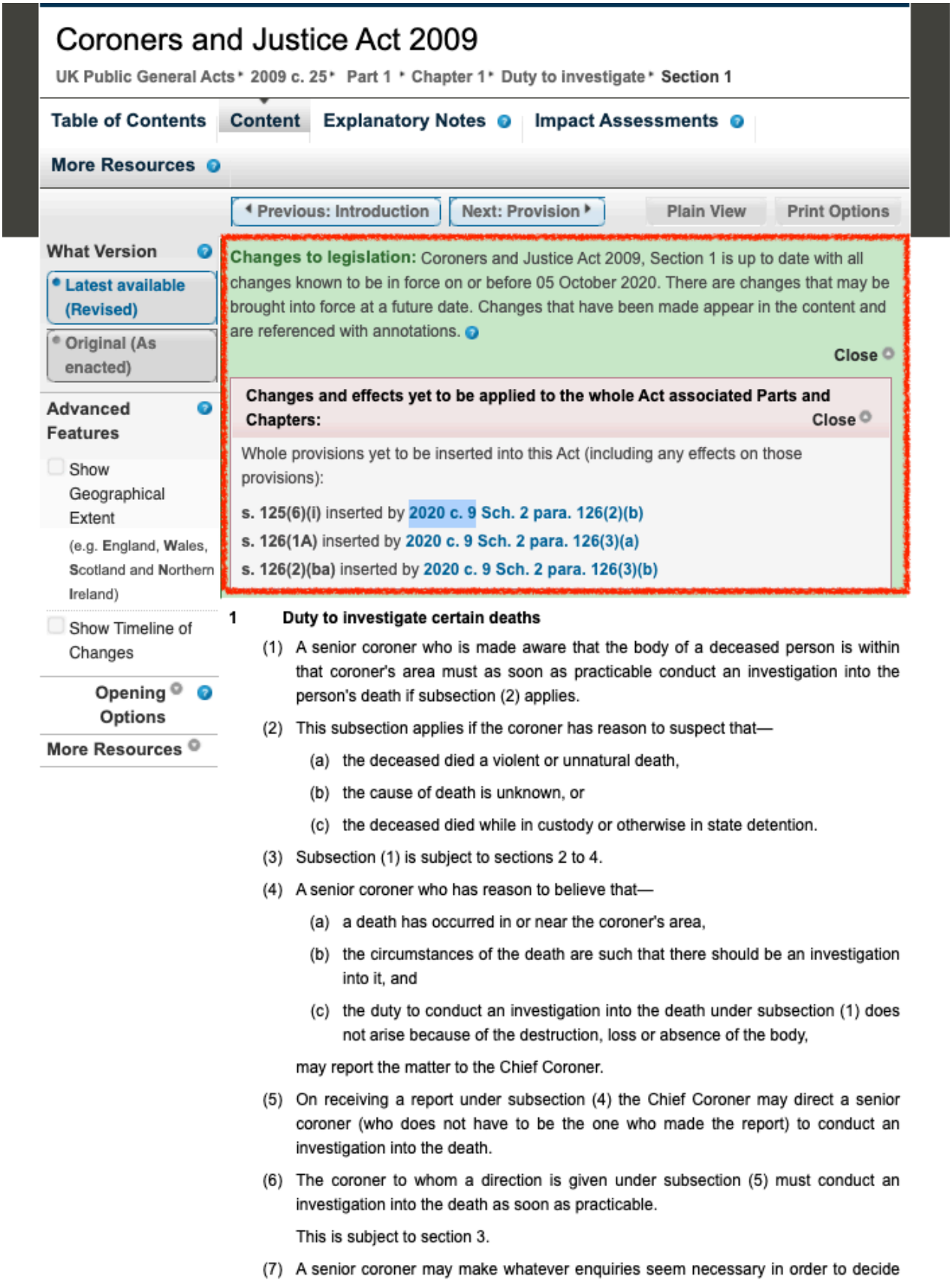
The colon cancer on line 1(c) led directly to the liver metastases on line 1(b), which ruptured, causing the fatal haemorrhage on 1(a). Adenocarcinoma of the colon is the underlying cause of death.

Update:

It appears that these changes were made in advance of Covid-19.



Coroners and Justice Act 2009

UK Public General Acts ▸ 2009 c. 25 ▸ Part 1 ▸ Chapter 1 ▸ Duty to investigate ▸ Section 1

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What Version

- Latest available (Revised)
- Original (As enacted)

Advanced Features

- Show Geographical Extent (e.g. England, Wales, Scotland and Northern Ireland)
- Show Timeline of Changes

Opening Options

More Resources

Changes to legislation: Coroners and Justice Act 2009, Section 1 is up to date with all changes known to be in force on or before 05 October 2020. There are changes that may be brought into force at a future date. Changes that have been made appear in the content and are referenced with annotations.

Close

Changes and effects yet to be applied to the whole Act associated Parts and Chapters: Close

Whole provisions yet to be inserted into this Act (including any effects on those provisions):

s. 125(6)(i) inserted by **2020 c. 9 Sch. 2 para. 126(2)(b)**

s. 126(1A) inserted by **2020 c. 9 Sch. 2 para. 126(3)(a)**

s. 126(2)(ba) inserted by **2020 c. 9 Sch. 2 para. 126(3)(b)**

1 Duty to investigate certain deaths

(1) A senior coroner who is made aware that the body of a deceased person is within that coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.

(2) This subsection applies if the coroner has reason to suspect that—

(a) the deceased died a violent or unnatural death,

(b) the cause of death is unknown, or

(c) the deceased died while in custody or otherwise in state detention.

(3) Subsection (1) is subject to sections 2 to 4.

(4) A senior coroner who has reason to believe that—

(a) a death has occurred in or near the coroner's area,

(b) the circumstances of the death are such that there should be an investigation into it, and

(c) the duty to conduct an investigation into the death under subsection (1) does not arise because of the destruction, loss or absence of the body,

may report the matter to the Chief Coroner.

(5) On receiving a report under subsection (4) the Chief Coroner may direct a senior coroner (who does not have to be the one who made the report) to conduct an investigation into the death.

(6) The coroner to whom a direction is given under subsection (5) must conduct an investigation into the death as soon as practicable.

This is subject to section 3.

(7) A senior coroner may make whatever enquiries seem necessary in order to decide

Related information:

> "Also good time to recall the other changes made in the Coronavirus Act to the way deaths are processed.

> *Only one medic needed to certify cause of death.
>
> *Cause of death can be pronounced or amended by a medic who never attended the deceased or saw the body after death
>
> This might explain why we see relatives complaining of altered CoD – and 'covid19' being added after the fact" ~ Catte Black, @OffGuardian

Covid 19 is a statistical nonsense by Iain Dale at Off Guardian:

> Not only did the act indemnify all NHS doctors against any claims of negligence during the lockdown, it also removed the need for a jury led inquest. Effectively, only in the case of death from the notifiable disease of COVID 19. Worrying as these elements of the legislation are, they are just part of a raft of changes singling out registered COVID 19 deaths as unusually imprecise.

Coronavirus and sectioning – changes to the Mental Health Act under Coronavirus Act.

> Section 5 holding powers can be used to keep you in hospital if you want to leave but your care team wants time to decide whether to section you. The team can use these powers if you are already in hospital, for example as a voluntary patient. These powers aren't relevant if you are in hospital because you have already been sectioned.
>
> Outside the emergency period, specially qualified nurses can keep you in hospital for up to 6 hours using these powers. This is to allow time for a doctor to assess whether to keep you in hospital for longer.
>
> During the emergency period, nurses will be able to use the same powers to hold you in hospital for up to 12 hours.
>
> Outside the emergency period, the doctor or approved clinician in charge of your treatment can use these powers to hold you for up to 72 hours.
>
> During the emergency period, the time limit for these holding powers will increase to 120 hours. And the person who uses these powers doesn't have to be the doctor or approved clinician in charge of your care, if this is impractical or would involve undesirable delay. In this case, any doctor or approved clinician can use the holding powers.

*

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