Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2019 – 2020

NHS SCOTLAND

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Senior Medical Reviewer Overview

Dr George Fernie
Senior Medical Reviewer

I am genuinely delighted to be presenting my fifth annual report which is a significant milestone for the Death Certification Review Service[1] (the service) and is an opportune moment to reflect back on progress made over this inaugural period. It is especially satisfying to consider what has been achieved, particularly when the process and content of the Medical Certificate of Cause of Death (MCCD)[2] has assumed much greater public prominence due to the Covid-19 disease pandemic.

We have attained a reduction in the 'not in order' rate, which is the measurement the Certification of Death (Scotland) Act 2011[3] states best demonstrates the quality and accuracy of an MCCD. Over half of all MCCDs reviewed when the service commenced required some change, compared to now, whereby some NHS boards have a sustained improvement and a 'not in order' percentage rate in the 'teens'.

Whilst there remains room for improvement, this suggests we are on the right track.

Had I predicted we would have effected this so quickly, I would have been concerned about over-optimism. However, the conscientious approach adopted by the team who have progressed the reviews in an educative and supportive manner, coupled with a responsive group of certifying doctors in Scotland, have helped us surpass our initial ambition.

We have continued to review MCCDs and **improve**:

- quality and accuracy, giving public confidence in the death registration process in Scotland
- public health information about causes of death in Scotland, supporting consistency in recording that will help resources to be directed to the right areas in a more timely way
- clinical governance, helping to improve standards in reporting deaths across Scotland.

[1] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information.aspx
[2] The MCCD provides a permanent legal record of the death, records information about the death (including the cause of death) and allows the death to be registered
[3] https://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf

Although quality improvement is the main reason the service exists within Healthcare Improvement Scotland, the fact we have demonstrated sustained improvement over this time span very much justifies our existence. This is at a time when the importance of the quality and accuracy within MCCDs has attracted great attention due to the consequences from infection by such a devastating Coronavirus. It has affected every person in Scotland, but in particular, people from our black, Asian, and minority ethnic communities.

Last year, we identified some areas we would like to focus on to support the continued improvement of certificates and the review process. I am pleased to report, we have completed some of this work and have made good progress in all other areas.

We have…

- reviewed how we manage enquiry calls to the service
- increased awareness of the death certification review process across Scotland
- improved the 'not in order' rate in all NHS boards
- improved the speed with which the outcomes of cases reported to the Procurator Fiscal are dealt with

We continue to…

In progress

- explore issues identified in the report of the Gosport Independent Panel
- ensure public health improvements go beyond deaths selected for review
- improve the quality of MCCDs submitted for review by the local authority registrars
- reduce the number of cases that are not completed within the agreed service level agreements
- promote and help pilot the use of (electronic) eMCCD in secondary care

Although there has been a heightened awareness by the team, especially of prescribing issues identified in the Gosport inquiry[4], no such systematic failings have been identified in Scottish territorial boards although a watching brief has been maintained.

Work continues on wider public health benefits where the service has co-operated with Public Health Scotland, particularly in considering the implications from the Covid-19 pandemic.

[4] https://www.gosportpanel.independent.gov.uk/

Analysis of administrative and process errors by certifying doctors and transcription errors by registrars is underway. The main impediment to completing reviews within the service level agreement is the unavailability of certifying doctors, however the breached rate remains reassuringly low.

Next year we will…

- complete piloting work to introduce the eMCCD into secondary care which will bring a number of benefits to families bereaved, NHS boards and registrars
- work with Health Boards to reduce the number of clinical errors on MCCDs, including appropriate reporting to the procurator fiscal

Dr George Fernie

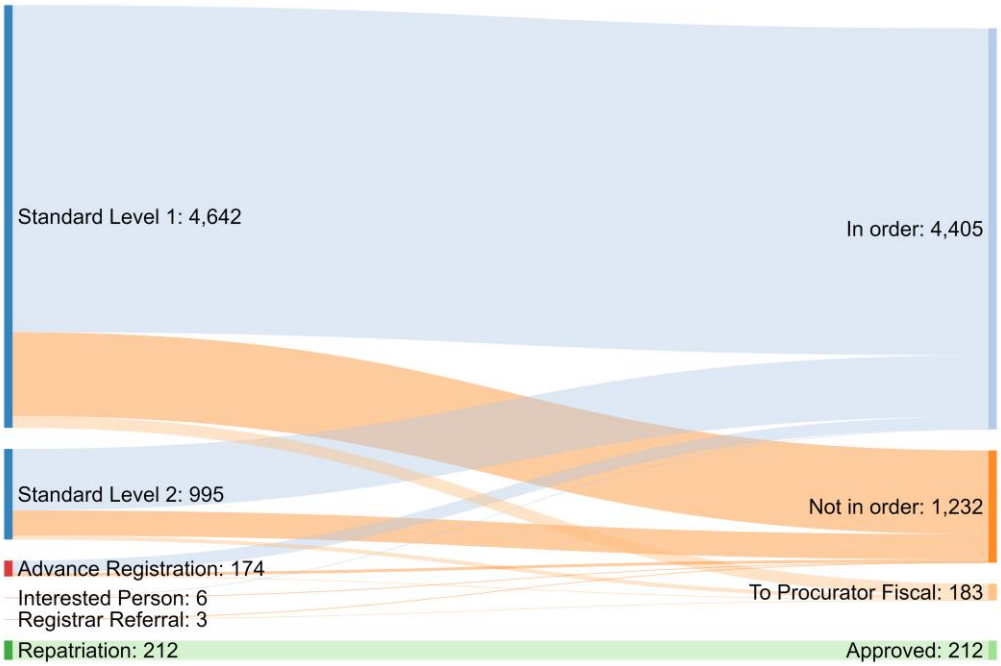
Senior Medical Reviewer
Death Certification Review Service

Quality, accuracy and consistency of MCCDs

Overview

The service reviewed 6,032 cases in the 2019/20 period. The diagram [5] below shows a breakdown by case type and outcome of cases received.

Diagram 1: Sankey diagram of number of cases and breakdown of case type and outcome in 2019–2020[6]



Number of cases

Of the 6,032 cases reviewed:

- 5,811[7] were **randomised reviews**[8] including standard Level 1 and Level 2 (93.5%) and advance registration reviews (2.9%).
- 221 **non-randomised reviews**[9], made up from repatriations (3.5%), interested person reviews (0.1%), and registrar referral cases (<0.1%).

[5] The Sankey diagram should be read from left to right. It shows how one category is broken down into components, then how a second and subsequent categories are broken down. The diagram shows the size of the connecting paths between the categories.

[6] Appendix 1 – Data table 1

[7] Randomised review data is from 1 April 2019 to 21 March 2020 due to randomly selected reviews being reduced on 22 March and suspended on 27 March 2020. More detail can be found in our Public Health Information (Covid-19) section.

[8] MCCDs are randomly selected for review by National Records of Scotland using an algorithm that selects approx 10% of MCCDs for a Level 1 review and the remainder receive a Level 2 review. In certain circumstances, the medical reviewer can escalate the case from Level 1 to Level 2.

[9] If an MCCD is not randomly selected for review and the death has not been considered by the procurator fiscal, members of the public and local authority registrars can request the service carry out a Level 2 review of the MCCD.

Overall, since the service began, other than a significant but transient increase during the winter months in 2017/18, the monthly number of cases has remained stable.

Randomised reviews

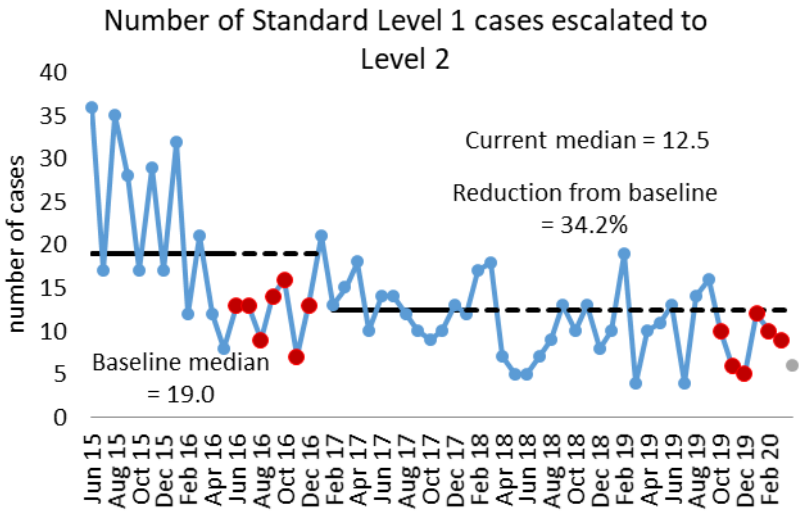
The average number of standard Level 1 cases selected for review remains around 372 per month. Level 2 reviews continue at an average of 77 MCCDs per month.

If a replacement certificate is required, or we have an unsatisfactory review with a certifying doctor, we are required to escalate Level 1 reviews to Level 2.

In the last 12 months, all reviews that were escalated have been because a replacement MCCD has been required.

Chart 1 below shows that from October 2019 there has been a decrease in the number of MCCDs requiring to be escalated to Level 2. This is very encouraging for the service and NHS boards and will enable families to progress with their funeral arrangements in a timely way.

Chart 1: Run chart[10] of number of Standard Level 1 cases escalated to Level 2 by month



[10] Run chart analysis gives a probability-based indication of when data changes over time by highlighting unusual patterns around a median. The first 12 stable months are used to calculate the median (solid line) and this is extended forward (dashed line) until the data changes. A run of six consecutive points above or below the median (red data points) is a sign the data is changing. New medians are calculated from the first point in a series of nine consecutive points above or below the median.

Advance registration

Families who are bereaved may need the funeral to go ahead promptly and the service aims to support this through our advance registration process.

The service can consider advance registration if:

- there are religious or cultural reasons (such as faith requirements to bury or cremate a person's body quickly)
- compassionate reasons (where delays would cause significant and unnecessary distress), or
- practical or administrative reasons (for example, wider family has travelled from abroad to attend the funeral).

Only 2.9% of all reviews last year requested advance registration[11], approximately 14 per month, of which

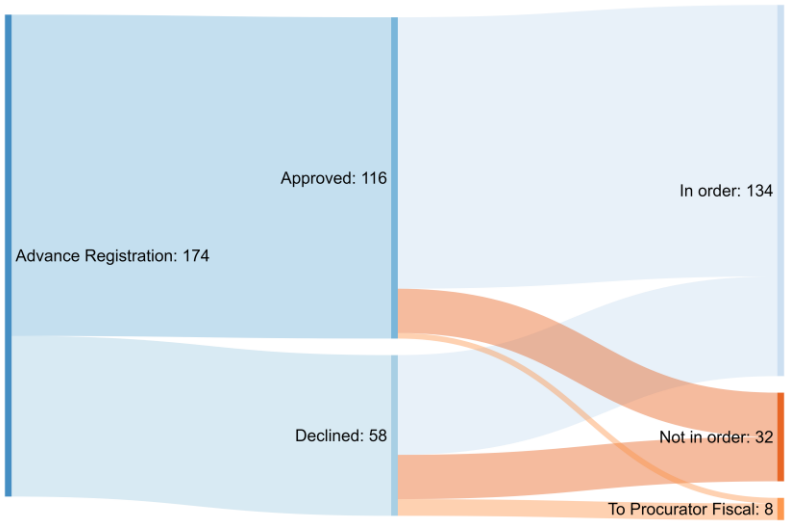
- 66.7% were approved, as the MCCD appeared to be substantially in order
- 33.3% were declined

Of the applications declined:

- 79.3% had either been completed or were nearing completion
- 10.3% required reporting to the Procurator Fiscal
- 10.4% were 'not in order' and required to be either amended or replaced.

The diagram below shows the breakdown of advance registration applications with outcomes.

Diagram 2: Sankey diagram of number of advance registration cases reviewed by month[12]



[11] Appendix 1 - Data table 2
[12] Appendix 1 - Data table 3

Decisions for advance registration should be made within 2 hours. In 2019/20, 98% of advance registration requests were successfully completed within this timescale and 99% were completed within 2½ hours.

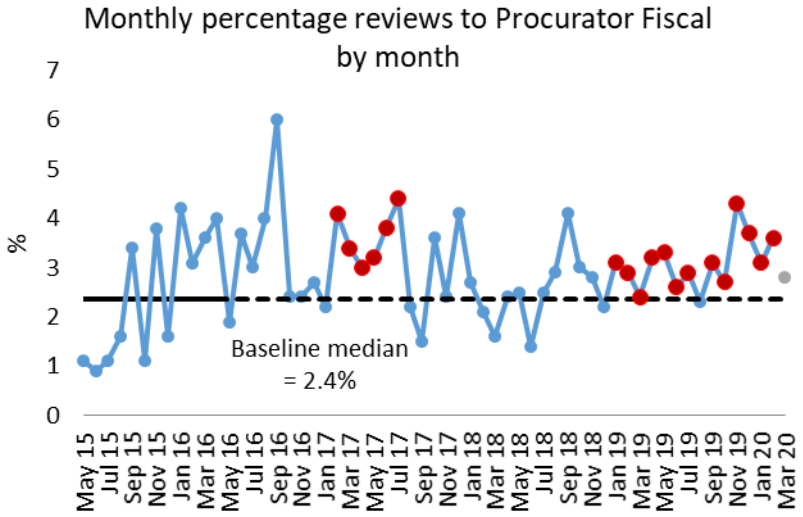
Reports to the Procurator Fiscal

Some deaths are required to be formally reported to the Procurator Fiscal[13].

If, during the course of a review, it becomes clear the death falls within the requirements for reporting to the Procurator Fiscal, the medical reviewer will recommend to the certifying doctor that they make a formal report.

Chart 2 shows the monthly percentage of all cases received by the service that should have actually been reported to the Procurator Fiscal. It averages around 2.4% per month; however, there is a sign this is increasing.

Chart 2: Percentage of reviews reported to the Procurator Fiscal by month[14]

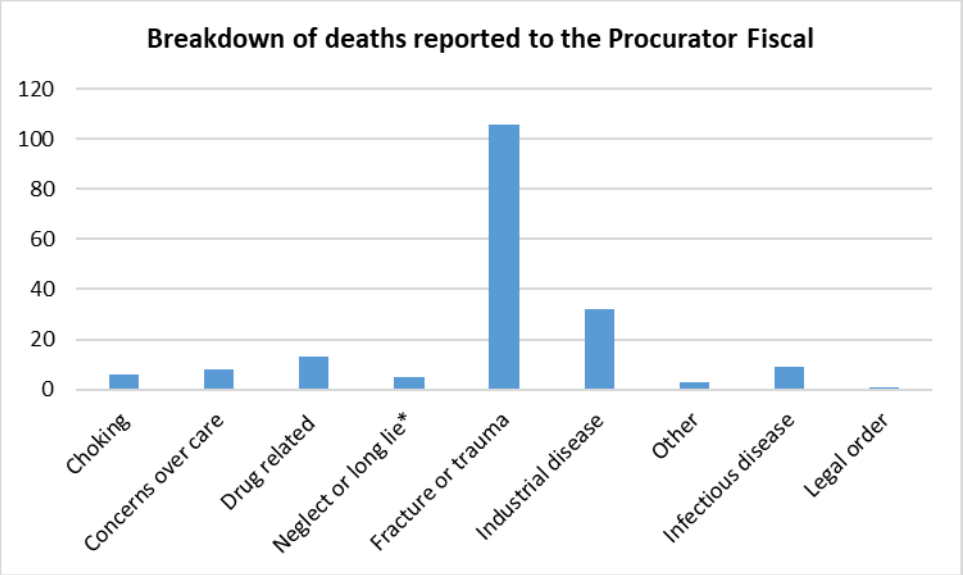


[13] Details of cases required to be reported to the Procurator Fiscal can be found on the Crown Office and Procurator Fiscal office website: www.copfs.gov.uk/publications/deaths

[14] Appendix 1 - Data table 4

Further analysis revealed, in the last 12 months, certifying doctors failed to report 183 deaths to the Procurator Fiscal in the following categories. Chart 3 refers.

Chart 3: Chart of breakdown of deaths reported to the Procurator Fiscal 2019/20



**Long lie is when a person has fallen to the floor and spends a prolonged time there because they are unable to get up. Long lie is a marker of weakness, illness and social isolation.*

Failure to report deaths to the Procurator Fiscal remains an area for improvement. Whilst we address issues with individual NHS boards during our regular Health Board reviews, we also work closely with the Procurator Fiscal and Police Scotland to achieve consistency around reporting of deaths in the community.

MCCDs not in order

A death certificate, also known as a Form 14, is a permanent legal record of a person's death and the role of the medical reviewers is to ensure the death is recorded accurately. The medical reviewer does this by assisting doctors in two ways,

- review (discussion with the certifying doctor and review of the medical record)
- enquiry (supporting the certifying doctor to improve the quality and accuracy of the MCCD)

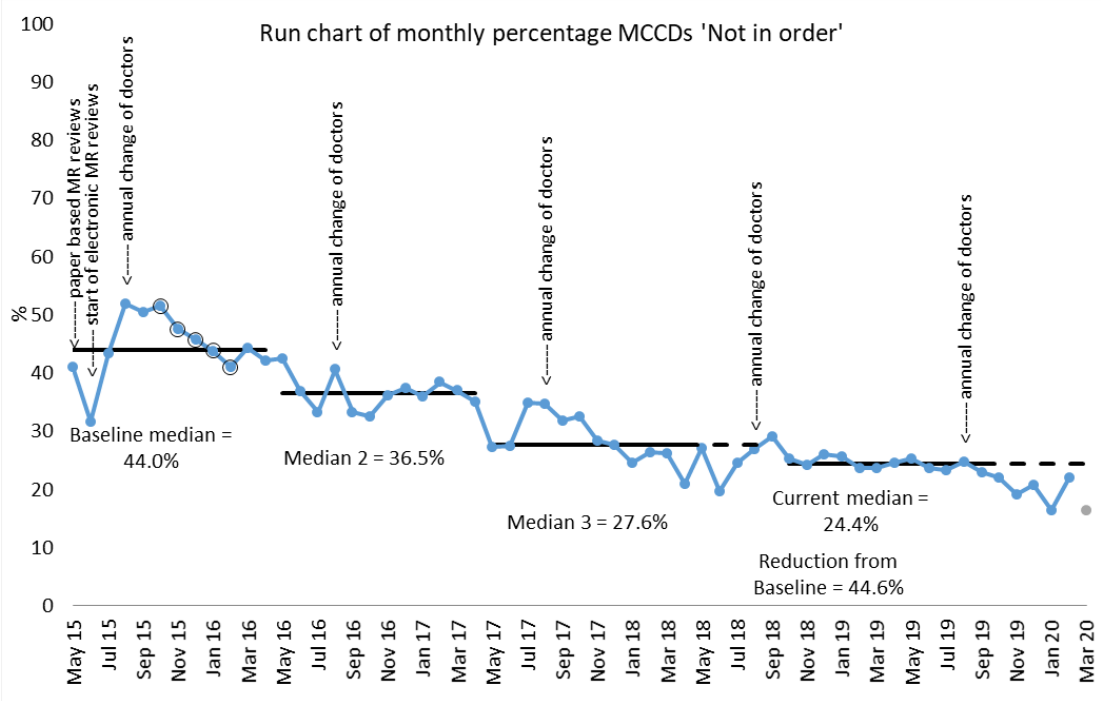
Reviews

All MCCDs reviewed by the service fall into two categories:

- 'in order'[15]
- 'not in order'[16]

Analysis of the monthly percentage of cases 'not in order' using a run chart indicates a percentage reduction, since the service was established in May 2015 of 44.6%, from 44% to 24.4% (see Chart 4). There are signs of further improvement in the last 6 months of 2019/20.

Chart 4: Run chart of monthly percentage MCCDs 'not in order'



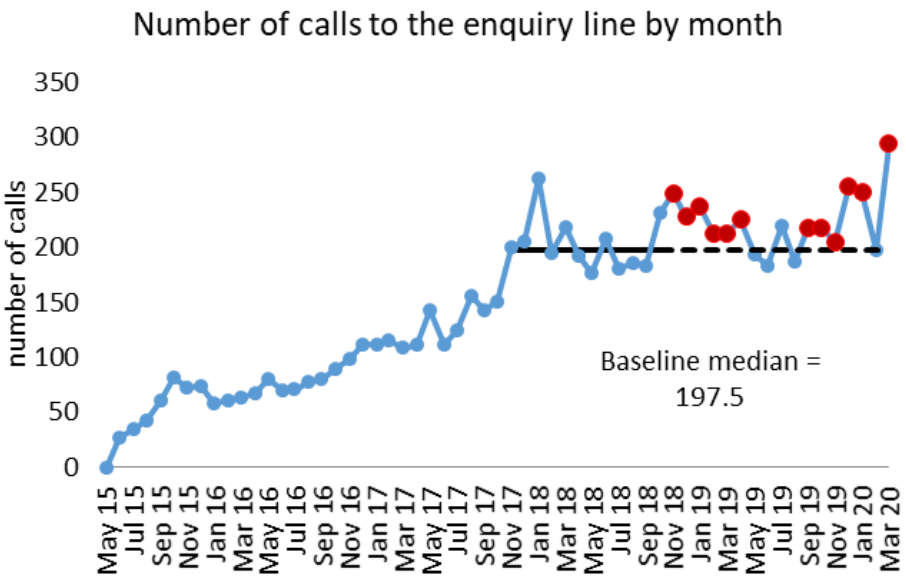
[15] The Certification of Death (Scotland) Act 2011, s8 (4) explains 'in order' as "where a medical reviewer is satisfied, on the basis of the evidence available to the medical reviewer, that:
a) the cause (or causes) of death mentioned represents a reasonable conclusion as to the likely cause (or causes) of death, and
b) the other information contained in the certificate is correct."

[16] 'Not in order' is when section s8 (4) of the Act is not satisfied.

Calls to the service

The service received 2,644 enquiry calls last year and as can be seen in Chart 5, there are signs of further increase. In March 2020, the service received the highest number of calls at 294 and it is worth noting that 66 of these calls were Covid-19 related. This temporary increase may not be sustained beyond the Covid-19 pandemic.

Chart 5: Runchart of number of calls to the enquiry line[17]



Example of enquiry call

Certifying doctor calls to discuss how best to represent the death on the MCCD:

A man in his 80s died suddenly with a past medical history of paroxysmal atrial fibrillation (occasional heart palpitations).

Had recently attended his GP with shortness of breath and chest tightness and was referred to cardiology (heart specialist) team. He generally kept quite well and lived alone with no family nearby.

The Out of Hours team were called as the man was reporting shortness of breath, chest and back pain. An ambulance was arranged. On arrival, the patient was sadly found to be dead. CPR was given but unfortunately the team were unable to resuscitate him.

Following discussion with the medical reviewer, the certifying doctor felt the cause of death was most likely to be an **acute myocardial infarction** (heart attack) due to longstanding upset of the heart rhythm (**paroxysmal atrial fibrillation)**. The doctor now felt he was able to produce an accurate MCCD which read:

[17] Appendix 1 - Data table 5

1a Probable Myocardial Infarction

1b Paroxysmal Atrial Fibrillation

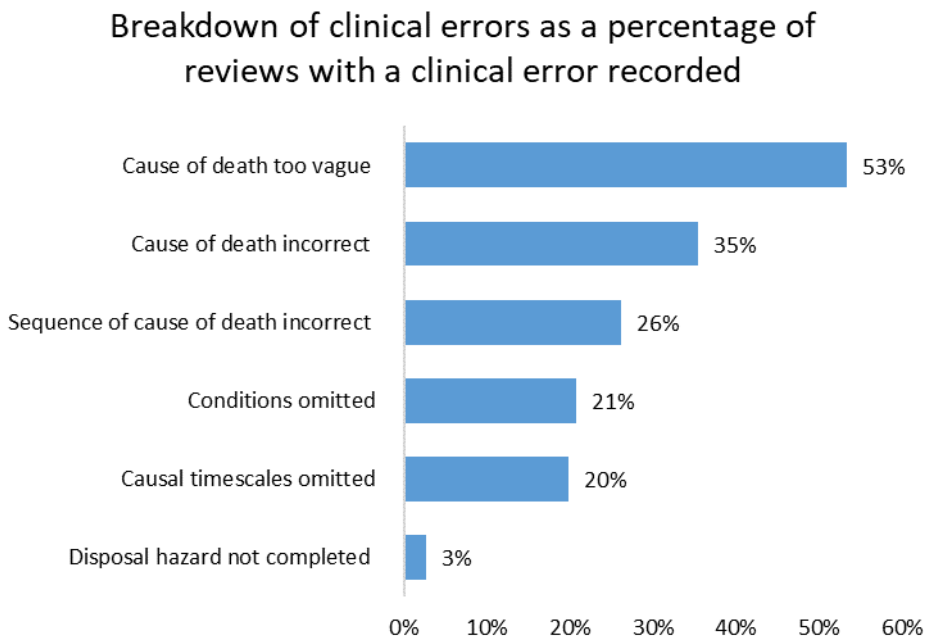
Outcome of ‘not in order’ review

MCCDs are deemed to be 'not in order’ if the certifying doctor makes a clinical or an administrative error.

A total of 1,228 randomised reviews were found to be ‘not in order’ in 2019/20, 75% of which were found to have a clinical closure category recorded. Chart 6 provides a breakdown of all clinical errors. The most common error recorded was 'cause of death too vague’, at 53%.

Chart 6: Bar chart of clinical categories recorded[18]

[18] Appendix 1 - Data table 6



We carried out analysis of the 'cause of death too vague and incorrect' category and the most common errors occur when defining:

- neoplasms (cancer) 7.5% of all reviews
- diseases of the circulatory systems (affecting the heart) 4.7% of all reviews
- diseases of the respiratory system (breathing) 2.0% of all reviews
- mental and behavioral disorders (dementia) 1.3% of all reviews

If the MCCD is not accurate, the medical reviewer will request the certificate is amended or replaced by the certifying doctor. In 2019/20, 91.9% of reviews found to be 'not in order' required an email amendment whilst 8.1% of reviews required a replacement MCCD[19].

[19] Appendix 1 - Data table 7

Example: 'Not in order' case, requiring email amendment as cause of death too vague

An MCCD included

1a – Metastatic cervical cancer	1 year
1b – Chronic kidney disease	10 years

The medical reviewer considered the MCCD and the patient Emergency Care Summary, noting chronic kidney disease does not normally cause cervical cancer, so the sequence of the MCCD was not logical.

The certifying doctor had also included his own personal mobile number, rather than the hospital number on the certificate.

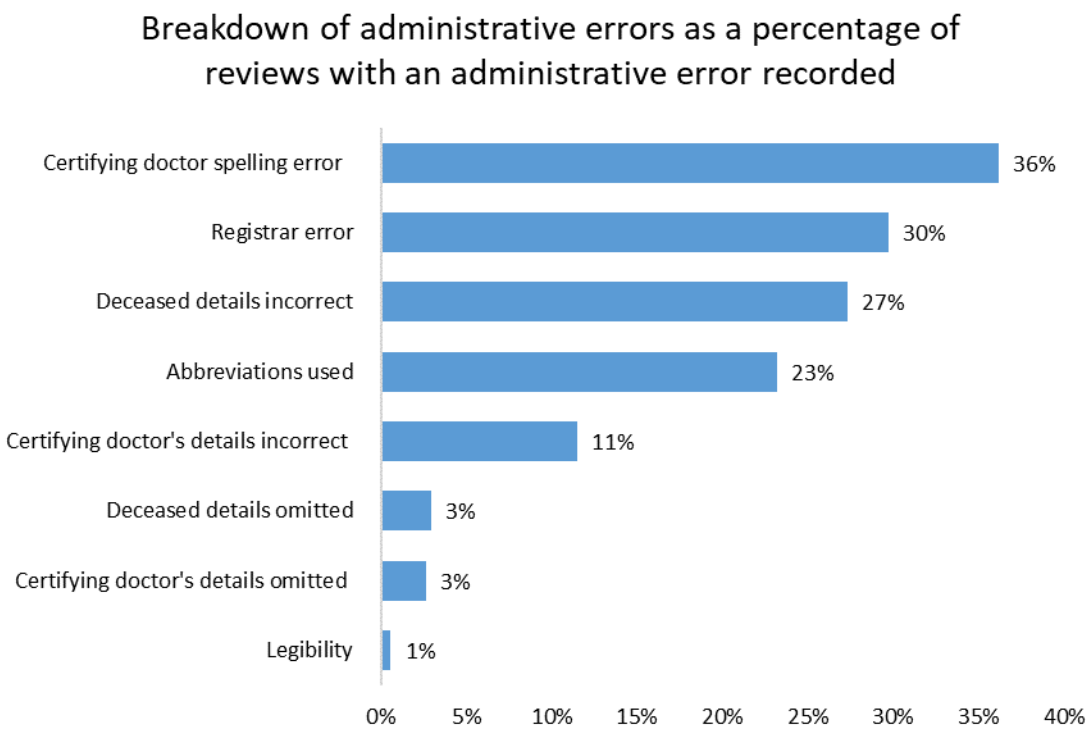
An educational discussion took place with the certifying doctor, FY1[20] who had recently moved to Scotland. On reflection, they felt part 1a could be more specific by adding the histology of the cancer and chronic kidney disease was not felt to be relevant. The patient had severe ischaemic heart disease of 20 years, which was felt to have contributed to the death. An email amendment to amend the MCCD was provided by the doctor and read:

1a – Metastatic squamous cell carcinoma of the cervix	1 year
2 – Ischaemic heart disease	20 years

[20] A Foundation doctor (FY1 or FY2) is a junior doctor who is undertaking a two-year structured programme of workplace-based learning. A bridge between medical school and specialty training

If the certifying doctor makes an administrative errors such as spelling mistakes, use of abbreviations, failure to complete the hazards section or sign the certificate, the MCCD will also be marked as 'not in order'. An email amendment or a replacement MCCD will be required. Chart 7 is a breakdown of administrative errors in the last year.

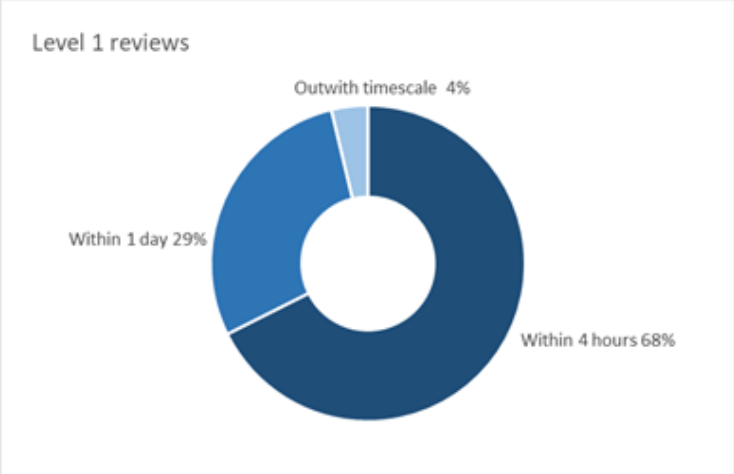
Chart 7: Breakdown of administrative errors as a percentage of reviews with error recorded



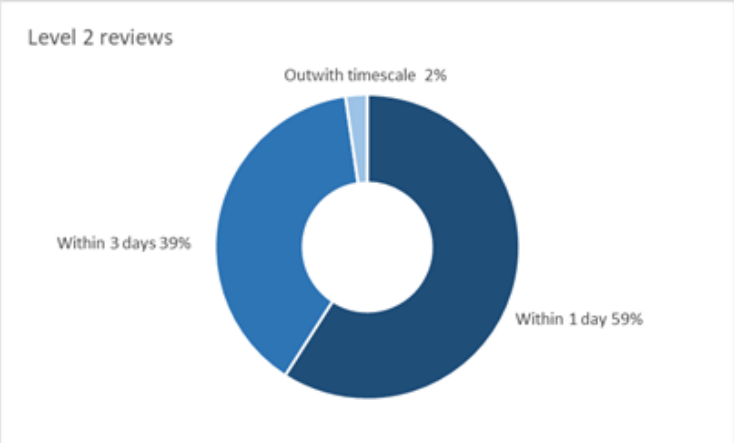
Breached Cases

Very few reviews breach the service level timescales[21]. Indeed:

- **96%** of all Level 1 reviews were completed within service level timescales
- **68%** were completed within 4 hours



- **98%** of all Level 2 reviews were completed within the agreed service timescales
- **59%** were completed within 1 working day.



[21] Service Level Agreement for completion of reviews is (Level 1 – 24 hours) and (Level 2 – 3 working days)

Non randomised reviews

Interested person, registrar referrals and 'for cause' reviews

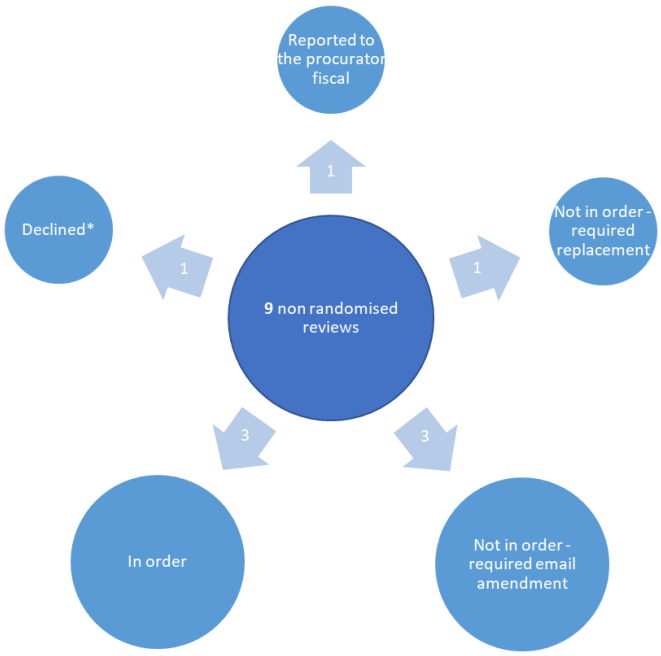
Members of the public can request an Interested Person review and registrars can refer an MCCD to the service for review if they feel the certificate is not accurate.

The service will carry out a Level 2 review, if the death has not previously been reviewed by us, or the death has already been investigated by the Procurator Fiscal.

The number of requests remains low, with only nine in the last year:

- six interested persons[22] reviews received from members of the public
- three registrar referrals[23]

Below is a breakdown of the outcome of these reviews.



**Declined as previously investigated by the procurator fiscal*

The Act states, where concerns have been identified, the service can carry out a review of a series of certificates written by an individual certifying doctor. This can be for a specified number of certificates or an agreed length of time. This is called a 'for cause' review.

No 'for cause' reviews have been undertaken by the service in the last 12 months.

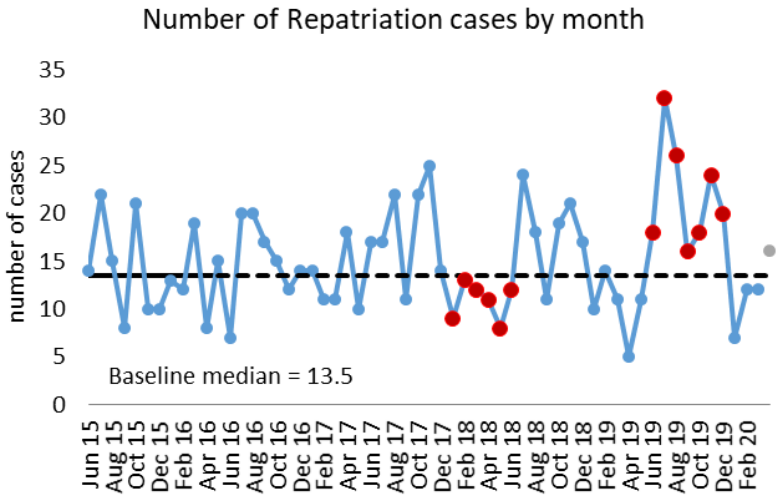
[22] Appendix 1 - Data table 8
[23] Appendix 1 - Data table 9

Deaths outwith Scotland (repatriations)

The service is responsible for approving burial or cremation in Scotland, of people who have died abroad and want to be repatriated to Scotland.

In 2019/20, the service received 212 repatriation requests, compared with 170 the previous year[24]. An increase occurred between May and November 2019. However, numbers have since returned to around an average of 14 reviews per month. Chart 8.

Chart 8: Number of repatriations cases by month



Of the 212 repatriation reviews requested:

- all were approved
- 67.9% approved for cremation, and 32.1% for burial
- two families requested a post mortem; both were approved
- two repatriations required documentation to be translated into English.

Repatriation audit – the first five years

Three of our medical reviewers have carried out a review of all requests for repatriation to Scotland since the service began in May 2015. Below is a summary of the key findings:

- 898 applications were received requesting burial or cremation in Scotland
- 34% of all deaths approved for burial/cremation in Scotland were from deaths that happened whilst the person lived in or was visiting Spain
- 73.5% of all deaths were of natural/medical causes with the main causes of death being cardiovascular (37.8%)
- 14.3% of all deaths were unnatural deaths or accidents
- 12.2% had no cause of death on the MCCD or were pending investigation in the country of death
- 65% of all repatriations were men.

[24] Appendix 1 - Data table 10

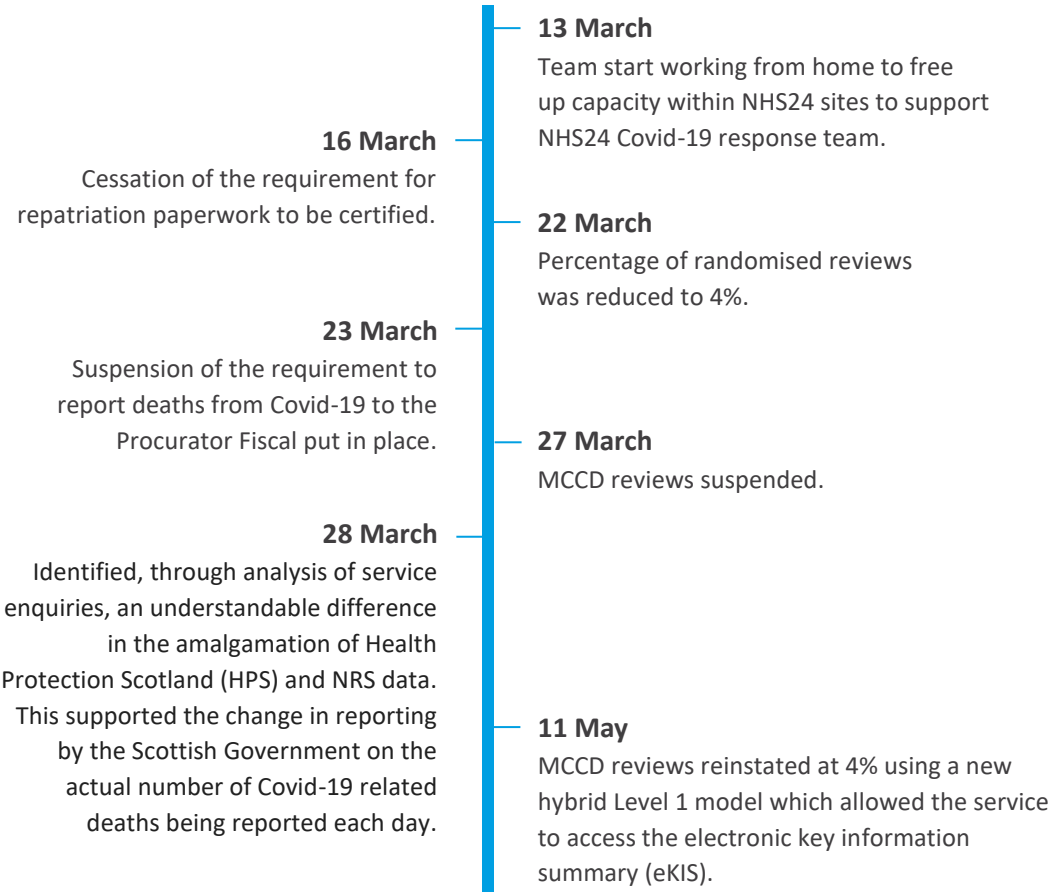
Public health information

Covid-19

Under section 2(7) of the Certification of Death (Scotland) Act 2011[25], Scottish Ministers have the power to reduce the percentage of MCCDs randomised for review or suspend by order, the referral of certificates to the medical reviewer during an epidemic, pandemic or if it becomes necessary to do so to prevent the spread of infectious disease or contamination.

In response to the Covid-19 pandemic, the service worked closely with the Scottish Government, National Records of Scotland, Registrars and the Procurator Fiscal and changes from the 'normal' service were put in place to support:

- Families and give public reassurance
- Health Boards and to reduce pressures on frontline staff
- Crown Office and Procurator Fiscal services to manage reports on deaths from Covid-19
- Registrars to manage the significant increase in death registrations
- Funeral directors to progress funerals quickly.



[25] http://www.legislation.gov.uk/asp/2011/11/section/2

To further support the national response to Covid-19:

- some service staff were deployed to other NHS work areas
- the senior medical reviewer assisted the Scottish Government in resolving information governance issues identified in relation to keeping patient personal information safe within the new remote death registration process
- staff provided virtual training at educational meetings in primary and palliative care around the new death reporting process
- the service provided guidance and support to certifying doctors through our advice line, and agreed with NRS that COVID-19 and Presumed COVID-19 would be acceptable abbreviated causes of death for entry in the national registers
- the service continues to monitor the situation, working with key decision makers to ensure our response to the pandemic is both responsive and appropriate.

Training and information

The service continues to support doctors, healthcare professionals, funeral directors, registrars and members of the public through the case selection and review process.

To support continued improvement we:

- continued to regularly meet with NHS Boards to discuss performance
- facilitated a number of external training events
- promoted our e-learning modules, with uptake increasing over the last 12 months

Certifying doctor experience survey

The number of cases reviewed for each certifying doctor this year has ranged from 0–16, with the highest number being from a doctor working in a palliative care setting where certification of death is more common.

Most certifying doctors have now had some experience of the service and we sought their views on their involvement of the death certification review process. They told us:

- staff were friendly and courteous 99%
- medical reviewers understood the case 98%
- review conversations were educationally focused 86%
- reviews highlighted the importance of accurate MCCD completion 88%

Feedback from certifying doctor

> *"I think the service is fantastic, although it takes a bit of time, I think it is educational and it's great knowing that the records are more accurate as a result."*

> *"I have found the review service more and more helpful as my experience and contact has grown. I have contacted them for advice about what to record as cause of death previously and have always felt that I have been given useful, educational advice."*

We also asked "What we could do to improve the service".

Area for Improvement	What we have done
Communication • An email before a call • Agreeing a mutual time to hold the review	Electronic certification is currently only available in primary care. This works extremely well, with the medical reviewer able to talk to the certifying doctor within minutes of them submitting the MCCD and in the main carry out the review. We continue to work with National Services Scotland(NSS) and NRS around eMCCD progressing into secondary care and we continue to arrange reviews with doctors at a mutually agreed time.
Education • More training and educational materials	The service continues to work with NHS Education for Scotland (NES) to develop educational resources to support medical staff in completion of MCCDs and improve communication with people who are bereaved[26]. In 2020, together we created a • short guide for non-medical staff, who might interact with people who are bereaved, around the time of receiving the MCCD. • short film taking you through the MCCD review process. • practice-based small group learning module on the completion of the eMCCD. • conference workshop presentation on managing legal processes following a death and interaction with the Procurator Fiscal. We continue to update our website with information on training opportunities and advice.
Operational • Shorten the service recorded telephone message	We have reviewed our message and have reduced this to less than 60 seconds.
Process • Looking through the notes electronically	The service has been in discussion with Health Boards around direct access to clinical portals. We hope by next year to have this in place.

[26] http://www.sad.scot.nhs.uk/atafter-death/death-certification/

A day in the life of a medical reviewer

Dr Sonya McCullough
Medical Reviewer

Dr Sonya McCullough is a medical reviewer. She joined the service in August 2018, with a background in obstetrics and gynaecology, genitourinary medicine, forensic medicine and latterly worked as a medicolegal advisor. Sonya explains 'a day in the life of a medical reviewer'. I still use my clinical skills as a medical reviewer, but instead of helping patients directly, I assist doctors to complete an MCCD accurately.

This involves ascertaining quickly the full facts leading up to the death and for some cases an assessment of the clinical records. I also try provide the doctor with a safe, supportive space to discuss the MCCD and where necessary agree changes to their certificate.

The service is busy. MCCDs are randomised in 'real time' and I am so aware, any delay in finalising the review, could cause a delay to the family registering the death.

In the space of a few hours, you can speak with a nervous FY1 undertaking their first review, a busy consultant surgeon in the middle of an outpatient clinic or a distressed family member, who is progressing a repatriation to Scotland following their relative dying abroad.

During a review, I ask the doctor to confirm:

- date and time of death (this should be when the patient died **NOT** the time the death was verified by the doctor

- death is not reportable to the Procurator Fiscal (so check if the deceased had a history of)
    - occupational exposure to asbestos
    - a fall that contributed to the death
    - being prescribed a medication subject to additional monitoring

- hazards boxes are completed to alert others if the body has
    - infection and could pose a risk to others
    - a cardiac pacemaker or other potentially explosive device that would prevent cremation
    - been exposed to or contains radioactive material, posing risk to public health

- certificate contains any other additional information in relation to postmortem
- clinical history, presentation leading up to the death, drug history, cause of death.

The role can be challenging, as it requires a wide medical knowledge, good communication skills, empathy and a good understanding of the death certification legislation. It is also very rewarding.

Complaints, concerns, comments and compliments

Feedback to the service is generally very positive, and complaints are infrequent.

In 2019-20 we dealt with **12** concerns of which **5** were upheld.

As part of service improvement, learning from all concerns raised are discussed during full staff training sessions.

In response to one concern, we have updated our electronic medical notes request system with the service contact details.

What we will do in 2020–2021

We will…

- Gather views from families on their experiences of the death registration process
- Seek feedback from doctors on how they find our Enquiry Line
- Work with NHS boards to reduce the number of clinical errors on MCCDs, create consistency in reporting deaths in the community to the procurator fiscal and encourage completion of e learning modules on the death certification review process
- Review the service response to Covid-19 and possible benefits and opportunities that have materialised during the contingency arrangements
- Continue to promote the use of electronic MCCD in secondary care.

Death Certification Review Service Management Board

The service is funded by the Scottish Government and is supported by the Death Certification Review Service Management Board. We hope that you have enjoyed reading about our work. If you have any comments please get in touch at DCRS@nhs24.scot.nhs.uk

Name	Designation	Organisation
Maggie Buettner Young	IT Programme Manager & Engagement Lead	National Services Scotland (Digital and Security)
Rod Burns	Deputy Registrar General	National Records of Scotland
Cathy Dunlop	Senior Registrar, East Ayrshire	Association of Registrars of Scotland
Lynda Fenton	Specialty Registrar Public Health	Scottish Academy Trainee Doctors Group
Dr George Fernie (Deputy Chair)	Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Angela Hay	Acting Operations Team Manager	Healthcare Improvement Scotland (DCRS)
Alexandra Jones	Public Partner	Healthcare Improvement Scotland
Michael Macmillan	Public Partner	Healthcare Improvement Scotland
Sandra McDougall (Chair)	Interim Director of Quality Assurance	Healthcare Improvement Scotland
Laura Mundell & Denise Bruce	Procurator Fiscal Representatives	Scottish Fatalities Investigation Unit
Cheryl Paris & Katrina McNeill	Policy Officer	Scottish Government
Alasdair Quinney	Associate Director	NHS 24
Alison Redpath	Data & Measurement Advisor	Healthcare Improvement Scotland
Dr Ruth Stephenson	Acting Deputy Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Andrea Telford	Acting Service Manager	Healthcare Improvement Scotland (DCRS)
Janice Turner	Principal Educator, Medical Education	NHS Education for Scotland

The management board would like to thank Dr Peter Wiggins, medical reviewer for his continued support with the service data.

Healthcare Improvement Scotland

The service is part of Healthcare Improvement Scotland, an organisation with many parts and one purpose – better quality health and social care for everyone in Scotland.

For more information visit http://www.healthcareimprovementscotland.org/

Appendix 1: Service data

The tables below provide a more detailed breakdown of the service data over the last 3 years[27].

Table 1: Cases reviewed by type

Case type	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Standard Level 1	4757	(76.1%)	4443	(76.7%)	4642	(77%)
Standard Level 2	1118	(17.9%)	1016	(17.5%)	995	(16.5%)
Advance Registration	179	(2.9%)	152	(2.6%)	174	(2.9%)
Repatriation	183	(2.9%)	170	(2.9%)	212	(3.5%)
Interested Person	2	(0%)	5	(0.1%)	6	(0.1%)
Registrar Referral	15	(0.2%)	6	(0.1%)	3	(0%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Total	*6254*		*5792*		*6032*	

Table 2: Advance registration application summary

Request outcome	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Approved	116	(64.8%)	97	(63.8%)	116	(66.7%)
Not approved	63	(35.2%)	55	(36.2%)	58	(33.3%)
Review outcome						
In order	128	(71.5%)	112	(73.7%)	134	(77%)
not in order	46	(25.7%)	38	(25%)	32	(18.4%)
PF	5	(2.8%)	2	(1.3%)	8	(4.6%)
Reason						
Administration, Compassionate or both	140	(78.2%)	126	(82.9%)	139	(79.9%)
Religion or faith	39	(21.8%)	26	(17.1%)	35	(20.1%)
Review Level						
Level 1	116	(64.8%)	95	(62.5%)	121	(69.5%)
Level 2	63	(35.2%)	57	(37.5%)	53	(30.5%)
Total	*179*		*152*		*174*	

[27] Data source: Death Certification Review Service case management system (Sugar) and National Records of Scotland.

Table 3: Advance registration reasons for not approved

Decline Reason	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Case nearing conclusion or already closed	54	(85.7%)	48	(87.3%)	47	(79.3%)
Hazards information not completed	1	(1.6%)	0	(0%)	1	(1.7%)
Incomplete application form	3	(4.8%)	1	(1.8%)	0	(0%)
MCCD not signed	1	(1.6%)	0	(0%)	0	(0%)
More appropriate for procurator fiscal	2	(3.2%)	0	(0%)	0	(0%)
Other	0	(0%)	4	(7.3%)	5	(8.6%)
Report to PF required	2	(3.2%)	2	(3.6%)	6	(10.3%)
Total	*63*		*55*		*59*	

Table 4: Cases reported to procurator fiscal by type

Case type	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Standard Level 1 and Level 2	167	(95.4%)	145	(96.7%)	174	(95.1%)
Advance Registration	5	(2.9%)	2	(1.3%)	8	(4.4%)
Interested Person	0	(0%)	0	(0%)	0	(0%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Registrar Referral	3	(1.7%)	3	(2%)	1	(0.5%)
Repatriation	0	(0%)	0	(0%)	0	(0%)
Total	*175*		*150*		*183*	
% cases reported to PF	2.8%		2.7%		3.1%	

Table 5: Number of calls received by the enquiry line

	Year 3 01 Apr 2017 - 31 Mar 2018	Year 4 01 Apr 2018 - 31 Mar 2019	Year 5 01 Apr 2019 - 31 Mar 2020
Calls received	2019	2497	2644

Table 6: Number and percentage of clinical closure categories for MCCDs with errors

Clinical closure category	**number**	%
Disposal hazard not completed	25	3%
Causal timescales omitted	183	20%
Conditions omitted	191	21%
Sequence of cause of death incorrect	241	26%
Cause of death incorrect	326	35%
Cause of death too vague	492	53%

Table 7: Number and percentage of 'not in order' cases by outcome

Review Outcome	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Email amendment required	1581	(91.7%)	1226	(90.8%)	1128	(91.9%)
Replacement MCCD required	143	(8.3%)	124	(9.2%)	100	(8.1%)
Total	*1724*		*1350*		*1228*	

Table 8: Number and percentage of interested person reviews

Request outcome	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Not Approved	1	(50%)	2	(40%)	1	(16.7%)
Approved	1	(50%)	3	(60%)	5	(83.3%)
Total Requests	2		5		6	
Time of request						
Before registration	1	(50%)	0	(0%)	1	(16.7%)
After registration	1	(50%)	5	(100%)	5	(83.3%)
Review outcome						
In order	0	(0%)	2	(66.7%)	3	(60%)
Not in order	1	(100%)	1	(33.3%)	2	(40%)
Reported to PF	0	(0%)	0	(0%)	0	(0%)

Table 9: Number and percentage of registrar referral reviews

Review outcome	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
In order	4	(26.7%)	0	(0%)	0	(0%)
Not in order	8	(53.3%)	3	(50%)	2	(66.7%)
Escalated to PF	3	(20%)	3	(50%)	1	(33.3%)
Total	*15*		*6*		*3*	

Table 10: Number and percentage of repatriation reviews

Request outcome	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Approved	183	(100%)	170	(100%)	212	(100%)
Not approved	0	(0%)	0	(0%)	0	(0%)
Total	*183*		*170*		*212*	
Method	Year 3 01 Apr 2017 - 31 Mar 2018		Year 4 01 Apr 2018 - 31 Mar 2019		Year 5 01 Apr 2019 - 31 Mar 2020	
Burial	65	(35.5%)	68	(40%)	68	(32.1%)
Cremation	118	(64.5%)	102	(60%)	144	(67.9%)
Post Mortem request outcome						
Approved	2	(1.1%)	2	(1.2%)	2	(0.9%)
Declined	1	(0.5%)	0	(0%)	0	(0%)
Translation required						
Yes	1	(0.5%)	2	(1.2%)	2	(0.9%)

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