**NHS Education for Scotland**

**Transcript of ‘Contextualising the review of the medical certificate of cause of death webinar (09.05.24)**

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**GW:** Well, good afternoon, everybody. This is our, welcome to our 22nd NES webinar. I'm Graham Whyte. I'm one of the Associate Postgraduate Deans with the Grief and Bereavement Team at NES,

and also consultant of Palliative Medicine at Marie Curie Hospice in, in Glasgow. So, I would like to welcome today's speaker, and the title of today's webinar is Contextualising the Review of the Medical Certificate of Cause of Death, and we're delighted that, excuse me, George Fernie who is the Senior Medical Reviewer and Caldicott Guardian is, is coming to speak to us today. George works for Healthcare Improvement Scotland with the, the Death Certification Review service there. And he is also Appraisal Lead for National Services Scotland and Partner Organisations. And he is also vice chair of the UK Caldicott Guardian Council and visiting professor at the, the Centre for Contemporary Law at the University of Bolton. So, thank you George for, for coming today. Now, just before we start, I just wanted to do a few housekeeping and outline what's going to happen this afternoon. So, the session structure is we're going to have about, 45-50 minute presentation from George, and there will be a number of polls throughout the presentation. So, we'll encourage your participation in those. And the remaining time that we have for the session, somewhere about 5-10 minutes at the end, will be dedicated to question and answers at that stage. So, we will be recording today's webinar and also the question and answer that will be at delivered at the end of that. We will ensure that any of the recorded question and answers is edited, so there'll be no, it won't feature any names or any other identifying information if you do end up asking a question. So, we'd certainly encourage you to, to do so. All of the attendees have your cameras turned off and your mics will be turned off. So if you do wish to answer any, ask any questions, please would you do that via the, the Q and A section that you'll see at the top of your screen and hopefully we'll be able to answer all your questions, but if for any reason we, we can't do them, please, if you still require an answer, get in touch with us at the Support Around Death website, and we'll put the, the email address in the, in the chat as well, so that you've got, you've got that. And similarly, if you have any other questions after the webinar finishes or any queries about the recording, please contact the Support Around Death team at the, at the email address. We will be subsequently posting the recording on the SAD website for anybody who's been unable to attend today. We will also be sending you out a feedback questionnaire at the end, so we really value your comments on the session and also any suggestions that you might have about future topics that you would like to hear presented and, and talked about so. So, without further ado, I think I'll hand you over to George, for today's session, so thank you.

**GF:** Sorry. Thank you, Graham. And Graham chairs the Bereavement Steering Group, which is one of the meetings that we prioritise at the Death Certification Review Service. And we find that there's so much benefit from that in, in regard to being able to, to being able to work with other stakeholders in a collaborative way. So, what I'm going to do just now is hopefully start sharing this with you. As you can see, the Death Certification Review Service is based at Healthcare Improvement Scotland, and that I think was one of the most important things that we did with being hosted by the Quality Improvement Scot, Quality Improvement Organisation within Scotland, rather than it simply being a tick box exercise with that.

So, the objectives today are to contextualise where we are with the review of the MCCD, the Medical Certificate of Cause of Death, demonstrating to you how we plan to get it right first time for families, an, an, an increasingly important aspect because the service has been going, going so well. And the advanced registration process, which is designed mainly for minority faith groups, is something that we think is worth reminding you about being there, a reflection on the management of adverse events and how we interact with the Procurator Fiscal, and finally, what we've achieved in the first nine years of the service.

Now, the first question we've got for you in the poll and, and bear in mind that I can't quite see the,

the same screen as yourself, is when did Tom Luce, and you may well ask, who is Tom Luce? Well, he was a Senior Civil Servant, and he conducted a significant review after The Shipman Inquiry on how we investigated death in the UK and, and indeed how we reviewed Medical Certificates of Cause of Death. And, and I gave evidence to him, on one of these years here. So, if we could have the poll to see when you think that might have been, bear in mind that this service came into existence in 2015. So there, there was a period, prior to that when we were in a proprietary phase. Now I'm not sure if we've got the result of the poll there yet. If somebody can just tell me that, please.

**GW:** We do have the result, George. It looks like 43% have gone for 2002, with 20% for 2000, and maybe about 20% for 2005. So, mm-hmm.

**GF:** Thank you. And that's absolutely right. So, it was 2002 that I trooped along Whitehall to give evidence to Tom Luce in regard to, what we thought should be done on a UK wide basis at the BMA.

And I was then fortunate enough to go onto chair that committee, and we, we, we, we, we implemented the system first in Scotland. So, next question for the poll is what proportion of deaths are randomly scrutinised in what is still the new Scottish system in that we are ahead of all the other home nations in the UK? And if we've got the result of that poll, please.

**GW:** It looks like, everyone's probably got this one right, I think, but 100% of people are saying option C for 12%...

**GF:** Fantastic.

**GW:** 10 responses. So, 10% of the audience.

**GF:** So, so we, we've got, we've got the, we've obviously got the message out there, which is brilliant, so that's great. And, next question, no trick to this, but we thought, again, just trying to put it into perspective, how many deaths occur each year in England and Wales? And you've got them there, 5,000, 50,000, 650,000, 1 million or 5 million. Hopefully we've got the result of that now.

**GW:** Again, 86% are saying option three, 650,000 with one or two for the, the smaller numbers.

**GF:** And that, that's absolutely correct with that. So, of those, and bear in mind in Scotland, were not a coronial jurisdiction, but there's a reason for this question here. How many of those deaths were reported to the coroner? And there's five choices there. So again, if we could have the poll in that, please. Have we got the answer there?

**GW:** And again, about 42% are saying 20,400 and, and 25%, 14,400 with one or, one or two others.

**GF:** Yeah, yeah. So, so it, it, it is now 210,000. Pre-pandemic it was about half the deaths in England and Wales were reported to the coroner. So again, a very significant number, but quite a change subsequent to the pandemic. How many coroners inquests were actually completed? So that's not just reported to the coroner, but how many actually had a full blown inquest and, and how many were completed? And this is 2015, this stat that I'm giving you here. And I appreciate it's a, it's a bit of a guesstimate with this, but do, do we have an answer to that?

**GW:** Just coming up, 30% were saying 26,000, 26% saying 46,000, 13%, 36,000.

**GF:** So, so just in the middle there. So, 36,000 actually had a full inquest that was there. Now in comparison, and you can see right away that it's a significantly smaller number here, but how many fatal accident inquiries were held in Scotland in 2015? And bear in mind, this is pre-pandemic, this is when we launched, and then I'll give you an even more interesting figure after that. So how many FAIs were held in Scotland in 2015? Do we have the poll for that now?

**GW:** 32% are saying between 20 and 40 and 24% between 50 and 70.

**GF:** Okay. And it was indeed 50 and 70, but during the pandemic, it dipped down to 42. Now, we'll go on and explain to the meeting just, how Fatal Accident Inquiries are convened and the basis for that. However, you'll see it's a very different creature that we have in Scotland to what happens in our immediate neighbour, in the jurisdiction south of the border.

So just taking you through some of this. We came into existence in 2015, and one of the, one of the main changes that set out here was, the, improve the quality and accuracy of MCCDs, to derive better public health information about the causes of death in Scotland. And, finally to enhance clinical governance in relation to death certification. And those three primary drivers have not changed in the first nine years of the service that, that we now have.

So, if we look at the basis, the statutory basis, it's an act of the Scottish Parliament, for the Death Certification Review Service. And here, here we have it set out, in this, this act. And if I can just highlight one or two things to you, we've got an application for review of certificates by interested persons. It's a little bit of a misnomer, but this is a facility that's there for a more detailed review within the three years after the person has died. And it's something that's typically in single figures each year. Although prior to the inception of the service, we'd thought there would be rather more than that. The next section of the act just to highlight is the request for the review, not to stay registration. And you'll say, gosh, what on earth is that? That's a real mouthful. Well, that's the advanced registration request that I alluded to previously. And we've got another question later on

about the number of those. But that was primarily there for the Muslim and the Jewish communities in Scotland who all have similar requirements in regard to burial, either as soon as possible before sunset or within 24 hours, but is not confined to that because in the north of Scotland, in the islands, the expectation is that you'll be buried within three days of the death occurring. And that's probably where we have the majority of the request for advanced registration. On the satisfactory review, we all know that doctors are not necessarily easy to deal with, but actually all of you that are certifying doctors have been absolutely brilliant, and we've never had what constitutes an unsatisfactory review in the first nine years of the service. We've had two instances where we came close to that, where I had to speak with the doctor concerned, but normally people have been entirely professional. They're aware that registration of the death cannot occur until the review's been completed, and they're very much bereaved focused on the needs of those that have just lost a loved one. I do have pretty swingeing statutory powers, section 14 and 15 of the act, and it's a criminal offense not to comply with my requirements there. Have I ever had to go anywhere near that? Well, again, no, it's not been necessary to do so. The Harold Shipman Clause, the section 16, duty to report suspicions of criminality, this is not us advising doctors that, the case needs to be reported to the Procurator Fiscal, but rather where we've had concerns about possible criminality. And we have had one such instance in the history of the service really quite near the start of it. And, and a, a thorough review was conducted by the major investigation team of Police Scotland, but at the end of that, no further action was taken. And, and again, it was in relation to the use of opioids that was there, and concerns were expressed on the quantity that was being prescribed. Another interesting aspect of what we do is death outwith Scotland, and that's the verification of people who die outwith the United Kingdom. And I'll show you some slides on that later on. And the final point, just to highlight to you was our training and information functions, I think of training as being something I do very badly with my wee dog, whereas I think it should be education, but we do take that obligation seriously as well.

So, what types of reviews do we conduct? We do the more basic level one review, which has changed slightly with the pandemic in that, in addition to checking we've got the right doctor, that's the GMC check and the CHI check to ensure that's the correct patient is there, we, we do a review, not just of the Emergency Care Summary now, but of the Key Information Summary. And as I think you'll all be aware, the amount of useful material that's in that has been significantly enhanced with the pandemic, with the delivery of care changing in the way that it has. We always do a review, a structured review of the Medical Certificate of Cause of Death, and I'm going to show you some educational materials that we've produced jointly with NES in a second. And we speak ideally with a certifying doctor or another member of the team who will normally be another doctor. But we, we can, benefit from speaking with a, a nurse on, on, on some of these occasions where it's difficult to contact that person either because of annual leave or because they've gone off shift. And we've got one working day to complete that review. And usually that's done the, the median for that's within four hours. The level two review in addition to what's in level one, we also look for some corroborative material by way of the hospital records, and we now have access to the clinical portal to that. So, it's increasingly rare that we have to ask somebody to scan and send that, and we have three working days in which to complete that, that function there. So, next question here. How many reviews do you think that the Death Certification Review Service undertook in 2022 to 2023 the year that's just passed? We're preparing the next annual report just now. So you've got a number of choices, five choices again there. And if, if we could do the poll in that, please. And do we have...

**GW:** 35% are saying 5,000, and we've got 26% saying 6,000 so the top winners.

**GF:** Fantastic, thank you. And it is, it is indeed 6,000 that are there. So, 12% of the deaths, and of course the number of deaths went up from pre-pandemic around 55,000 to 62,000 plus after that. And we have had a sustained increase of about 10% of the total number of deaths. So non-Procurator Fiscal deaths that we look at and we advise about 3% are, should have been reported to the Procurator Fiscal. It went up a bit during the pandemic. It went up to over 5% at one point,

but it's, it's come back down quite nicely with that. So apart from inflicting, a review upon you from DCRS, which I would hope would always have been done in an educative and supportive manner, which is our ethos, we also welcome you calling into us. Now, this is a completely anonymised slide that's there, and that, that CHI doesn't exist, that's, that's on that. But what we do have here, is a typical inquiry that we receive about three quarters are from primary care, but the remainder are from secondary care or hospices as well. Like everything else in medicine, if you're regularly dealing with death, for example, in a hospice background, then you tend to become quite good at certifying in those circumstances. And, we also have the situation increasingly with our deaths in the community. So, this is a typical one. It's a, what I would call a natural death. Police and the Fiscal tend to refer to it as a medical death, which I don't think is the correct terminology. This is a natural death of an elderly person that's been found at home with nothing suspicious that's there and, and confirmation of death, which is the preferred terminology now is, is that that's been undertaken by the Scottish Ambulance Service. So, we've had a discussion. The doctor there has taken the view that it would be reasonable to the best of their knowledge and belief to provide a, a certificate. And we've discussed what might be contained within that. Now, again, we've got abbreviations here just in the entry that we've completed, but 1A uses a qualifier probable, so probable or likely would be the types of qualifier that the CMO would, Chief Medical Officer, in the guidance would find acceptable, and we would probable myocardial infarction of one day's duration. National Records can't code zero days at, at 1A and part two, smoking hypertension and chronic obstructed pulmonary disease. And we've discussed whether or not the case did require to be reported to the Procurator Fiscal and decided not to do that. So that's an absolutely typical inquiry that we get there.

Again, just going to the certificate. The certificate was updated prior to inception and the electronically completed certificate coming into primary care, a, a year prior to that in 2014. So, the, the, the standard of proof is to the best of your knowledge and belief, certainly not the criminal burden, which is beyond reasonable doubt. And I don't think it's even the balance of probabilities 51%, which would be the civil burden of proof. So, it's to the best of your knowledge and belief that you're certifying there. We did make some other changes to the MCCD and again, incorporated what used to be in the cremation forms on hazards, and that includes, is a risk to public health, it's assumed considerable importance with covid and the pandemic. Although, to begin with, certainly we didn't have an evidence base of whether or not a particular period would constitute a hazard. And, and perhaps it's still not quite as clear as we would like, that is something we would discuss. Those of you who have read Iain Banks will be aware of the Crow Road and his grandmother exploding in the crematorium with the cardiac pacemaker. In reality, it's perhaps not quite as spectacular as that, but it does cause damage and it's obviously very distressing to the family. So, so we, we, we, we, we do take that check very seriously, and if that's wrong, that would require a re-issue. And of course, is there a radioactive material, for example, seeding of the prostate or other hazardous implant currently present that are there. And a slight peculiarity of the Scottish jurisdiction is the attendance in the deceased. And it, it's not necessary to have been in attendance. So, an A3, and this is because of our geography and, and the islands and having to transport bodies after death. No doctor was in attendance in the deceased. So, ideally you would hope that somebody was there, but nevertheless, it's not, not a, a, a legal requirement. And, and indeed this is clarified within The Registration of Birth, Deaths and Marriages Scotland Act 1965 which is cited within the certification of Death Scotland Act that I mentioned earlier. Any registered medical practitioner who is in attendance must it's not, not may, but must within seven days after the death of the person, transmit either to the inform or to the district registrar a certificate signed, and I discussed the basis for that already.

So, there are interesting things, of course, that crop up from time to time, and those of you that follow the media avidly, as do I, will have, this will not have escaped you. And this was the, the, the death in Aberfeldy where initially the deceased was conveyed to a mortuary, and it was only later on that it was discovered that they'd actually died from a, I think it was separate gunshot wounds. I, I don't have any direct knowledge, but that was, that was what we had. So, there's always this slight apprehension in the background. But we do take a team approach and increasingly we're having other healthcare professionals confirm death. And, and this was picked up, but just not perhaps as quickly as would've been desirable.

So, what's the metric we use? We're a quality improvement organisation, but how, how is it that we determine whether you're doing a good job and we are doing proper reviews? Well, the, the act, the Certification of Death Scotland Act sets out this metric. Well, it sets out the in order metric, it's the not in order rate that we'll use, and we'll come back to that shortly as well. But what, what is in order? So, for the purposes of the legislation, it's in order where one of my team is satisfied on the basis of the evidence available that the cause or indeed causes of death mentioned represent a reasonable conclusion. So, it's reasonableness, it's a professional standard that's in place there as to the likely cause or causes of death. And indeed, that the other information, the administrative detail contained in the certificate is correct. So that's, that's what we use. And we have a, we have a very detailed standard operating procedure in order to do that.

And I mentioned before the importance of this into Scotland, to the minority faith groups particularly. And, and I, until I started doing this job, I didn't know how many were in the Muslim community. It's around 60,000 and how many are in the Jewish community. It's about, it's about 6500 that are there. So again, this is something that is of importance to them. And, and, and, and we, we, we do, as I say, try and pull out all the stops with both this and, and as a safe way, there's a,

a requirement in the north of Scotland. So this is the information that we have on our website at,

at DCRS. And, there are different reasons, by which you can justify an application for advanced registration. Religious and cultural, as I’d mentioned, compassionate and, and this word compassion really underpins all that we do because we, we think it's so important that we get that right for relatives and we avoid any unnecessary delay or contributing to the distress that they're, they're going through and practical administrative. And, and indeed you'll recall just over a year ago that Her Majesty the Queen died at Balmoral. And we, we, we were waiting there with some anxiety in case we got a request for an advanced registration if, if the case was going to be selected for review. And we, we thought, well, yeah, probably a state funeral would constitute a practical or administrative reason for advanced registration were we ask to do that, and certain information is, is required there. And you'll see that we would normally expect to be able to confirm if the funeral can proceed within two hours of the request being made. And, and that's an example of the form that's there. And we now have an addendum to that, that if there are any deadlines that are important, if, if there's any particular time or date that's important to that family, then we ask for that to be included as well so that we can try our best to help with it. Why, why would we not, why would we not actually grant, an application? Well, the reasons we would grant, not grant it would be if we believed it's likely that it would have to be reported to the Procurator Fiscal, and it doesn't have to be perfect, the certificate for us to authorise advanced registration, but it has to be substantially in order is, is the phrase that we would use for that.

So, next question, and again this is just to put in context and see how things have perhaps changed. How many advanced registration requests did DCRS receive at the start of the service 2015-2016. And as usual, you've got five, five choices there. So, if we could run the poll in that, please. And what's the outcome of that, Graham?

**GW:** We have 35% saying 57, 27% 107, and 10% 307, so.

**GF:** Thank you. And indeed, indeed, the 307 is the right answer to that. So just bear that in mind

that figure, that was in 2015, we had 307 requests for advanced registration, and that was at a time of significant change, and there wasn't the confidence in the service that perhaps there is now. So, in, in 2022-23, and it's even better if that's the right way of phrasing it, in this most current year,

although we don't quite have the finalised data for that yet, how many advanced registration requests did DCRS receive? So, have we got the poll on that now?

**GW:** Yeah, we're just waiting for the results. 42% were saying 573, 25% 273 and, and 17% 73.

**GF:** Yeah and, and it is indeed the 73. So, I, so I, I think that is because we do have this confidence that we are processing, it's a dreadful word using processing with this, but I think, you know what I mean, we're, we're dealing with it real time. There's not a waiting list here. And we, as I say, try and ensure we have a traffic light system on the, on the electronic case management system that we have that, that alerts us if a case might breach there.

So, again, putting it further into context, this is what I call the etc act, because it's got the word etc in it or the abbreviation etc there. So, what happened with, FAIs changed somewhat, in 2017 when this act came into force. So, there are mandatory and discretionary inquiries in Scotland. So, the death occurs in Scotland, although there's an extension of that now in certain circumstances to outwith our own jurisdiction. And it's mandatory if, if somebody dies while in the course of their employment or occupation, and that of course, became relevant with the pandemic. If a healthcare professional died, then there would be a mandatory Fatal Accident Inquiry. Or indeed, you'll, you'll remember at the start of the pandemic, there was concern for bus drivers, for example, there. And the other situation is a death in legal custody, which might be a prison or, or, or in, in the police cells that are there or in court premises. Discretionary Inquiries, which are the ones that affect the medical community far more are something that I dealt with regularly when I, before I joined Healthcare Improvement Scotland 10 years ago. I worked for two of the UK medical defence organisations, MDDUS for, for, 13 years and then MPS for, for four years. And Discretionary Inquiries are much, much less frequent. So, I mentioned earlier on in the quiz, we, we asked you how many had been, and I said it even gone down to about 42, one year that was there. But most of those were mandatory inquiries. And there's only a handful that come into this, this group here. And that's where there's concern, either that the death is sudden, suspicious or unexplained or occurred in circumstances giving rise to serious public concern. So, it's like giving rise to serious public concern that tends to be the medical FAI, but there's a proviso with that. And it's in the public interest for an inquiry to be held into the circumstance of the death to see if there are any systems or failures that can be identified and, and remedies can be put in place to avoid that happening in the future.

So, so, so let's have a look here. And we, we talked earlier about the vast number of inquiries in England and Wales in comparison, but you'll see the data there, and that's the year I mentioned 2021-22, where there were only 42 concluded FAIs, with the vast majority of them being mandatory. And these are figures from COPFS, the Crown Office that are there. So, reports to the Procurator Fiscal. So, this was interesting in as much as our medical review team found that 3.9% of all certificates reviewed by the service, that's the random 12% should actually have been reported to the Procurator Fiscal, and we advised accordingly, and those, those were made. And you'll ask, well, what is it that we're missing? And, and it, it's, it's mainly fracture or trauma. And we had a, a case today, where there was a query and it's 95 year old woman that had died, but there were a number of rib fractures and, and a, a more significant fracture that's there. So typically, it's trauma and it's usually and what the Fiscal's interested in particularly is if it's proximate to the cause of death. So, the cause of death may ultimately, as in this case I'm mentioning, had been a hospital acquired pneumonia, but it was preceded within a couple of weeks by, by, by an accidental fall. The other thing is industrial disease and asbestos mesothelioma or indeed a, not disease, but a marker of exposure, plural plaques, and they need to be reported as well. And of course, infectious disease with covid and concerns over the care and, and choking when people should have been on a special diet but perhaps have, have not been. So that's the sort of circumstance.

So, we, we've looked at all of this and this is something that we've put together from DCRS, and we've had assistance from NES with this. And it just gives you an indication here of where are the most common errors here, what do people tend to perhaps not get quite right, like I prefer not get quite right rather than wrong, but 19% when the patient died, not the time death was confirmed by a healthcare professional and, and, and where, where the death occurred. And, and please, if you're in secondary care, put the word details if somebody died in hospital. So, we can do that. The proper business address for the certifying doctor and not your personal mobile, because again, this is communicated now with remote registration being in place to the, the relatives and cause of death, again, oldest to most recent. So, the chronology has to be right with that. And, and there's been some expansion. Scottish Government have been pretty helpful, the Scottish Government Health Directorate with allowing more abbreviations. Previously it was only HIV and Aids, and we've expanded that. But, but, but that's there. And the, a, a common error that continues to be from time to time, CVA, which is, is not correct. And the word accident has worrying connotations for the, the relatives as well.

So, the other side of that document that we've produced is again, please, please use a, a, a tick or a cross there. And there's this issue that I touched on previously about whether or not the body is a hazard there with the DH1 box. And again, we, we get errors with attendance. And, and if, if you've been providing repeat prescriptions for a deceased patient, then you've been in attendance of them. If another member of the healthcare team in the practice has, has been in, has, has been looking after them, then you've been in attendance with that. So, it's, it is unusual, but it's not unknown. Much earlier in my career, and this doesn't happen anymore, but as a, a forensic medical examiner, I, I would be asked to go and view a deceased that was there, and I would be invited regularly by the Procurator Fiscal to what we call a viewing grant in Scotland, having been to the locus where the person had died and conducted an external examination of their body, I would then be invited to, to issue a certificate. And that would be no doctor was in attendance, and I, I wasn't in attendance then, but those were very specific circumstances. And, and finally this bit about if waiting for histology or toxicology that may add to detail, but, but only in those circumstances, not a, a more general possibility of that. So, please check the spelling. You, you, you would say, or you would hope, nowadays we might have a, a, a, a spell checker with the electronic MCCD. Afraid we don't have that yet. I'm, I'm ever hopeful that before I retire, we might, might have that facility in place to help you. We do say that our preferred option is writing in black ink and block capitals. Now, there's no law that says you have to use black ink, but it's common sense and best practice, and that's why we promote that. And again, just double check, you've completed both, both sides of the form and with the EMCCD that has been signed with that.

So, this is a Sankey diagram, and we, this was for 2022-23. You'll see that we had a certain number of level one and level two reviews that are there, but we also had a, a hybrid level one, and that was within the pandemic, that for periods of time to reduce the pressure on both primary care and acute, we, we used that. And then, and normally you'd have a couple of thousand level two cases a year. But as I say that, that year it's slightly different with it. And the, the number of interested person reviews has gone up slightly from that. It's four and, and you'll see there that we have a couple of hundred repatriation cases a year as well.

So, so that takes us on seamlessly to death outwith Scotland and repatriations and 22-23, as I say just under 200, and you're, you're more likely to die abroad outwith the UK technically if you're male rather than female. Don't ask me to explain that. The demographic is pretty much what you would expect I think there. All death is tragic for those that have lost a loved one. But these are particularly so, and typically these are not necessarily natural deaths that we have there. And there are some countries that seem, to, to have a greater likelihood of death. I think that's just because we, we visit them more than, than you would expect from Scotland there. So, the repatriations here, and, and again with the 2016 act, the etc act I mentioned earlier, coming into force, we, we do now, where there are concerns, if there's a sudden unexplained or unexpected death we advise that that should be reported to the PF and we make that referral there. We have a very good working relationship with our colleagues at SFIU, the Scottish Fatalities and Investigation Unit. And, and these are the number of cases that have been reported there. We have, as I say, very tragic cases. This was before the, the act came into place the, the, the FAI revision, and this was a balcony fall. And many of you will have read about this in the media. This is from the BBC Scotland feed here. And again, the issue is has it been accidental a fall, has it been intentional or has it been a criminal act? And all those sort of things are, are, are mixed in with that. And indeed, we've worked with the, our justice colleagues at Scottish Government and we have a memorandum of understanding with them in order to try and support families who have lost loved ones through a possible crime that's there. So, we, we have in certain circumstances where somebody, and this is cases that may not go to the Fiscal or indeed before we had that ability to do so, if a person dies outwith the UK, the body is to be disposed of in Scotland and no cause of death is available then I'm, I'm allowed to instruct an, an autopsy, an invasive autopsy. And, and that's currently having gone through the procurement processes with the University of Dundee, and we have a, a, a, a small number each year where no cause of death is available at, at the time that we receive the application in that qualification there that we, we will make that arrangement bearing in mind, there are some issues where somebody perhaps has already had a postmortem there, there may have been in a warm climate, the degree of decomposition, or they may have been embalmed. So, so the, the results are not, not always ideal.

However, probably better than we were told before that.

So, we're just starting to wind up just now. And I, I, I don't get any I, I don't get any fees for the chapter I wrote in this book. I thought selectively quoting from it might be of some, some benefit. And I talked about enlightened decisions in, in the chapter I contributed. And although the act in theory permits the charge to be levied, we took what I thought was a bold decision at the time. And, and I very much was in favour of this because all of us die at some stage that we shouldn't actually have to pay at the point of delivery. I thought that wasn't in keeping with the NHS as it was originally conceived, and it should be paid for out of central funds. And indeed, that's what we've done. We've also, in contrast to south of the border and, and, and Northern Ireland we, we've got an arrangement where we don't levy any cremation fees that are there. And we have an independent system because we're hosted in Healthcare Improvement Scotland as a quality improvement organisation. So, it's not just a tick box exercise, but we've got clinical governance as our core function. And, and I, again, I've said here, and I think it's reflected in the next slide, it's not, doesn't mean that one system is better or worse than the other, but it is different in the same way as, as, as the NHS has diverged slightly across that. So, we were the first of the home nations to reform the review of Medical Certificates of Cause of Death. And it was done on time and under budget by some miracle, despite requiring a new IT system connecting to intergovernmental departments. But it, but it worked. We turned on the switch and it, it worked, and it's been brilliant, and we've had some updates since then as well. And we have affected a significant and sustained improvement.

So, I think this is the final question that I've got for you. So, I've said we've done a good job, but the monthly percentage of MCCD's found to be not in order, the metric I described, have seen a sustained improvement of, and you've got five choices there. So, if we could run the poll for that for the final time, please. And do we have a result of that, Graham?

**GW:** We do, yeah, I think 28% are saying the 51.5% and maybe 20% for some of the, the other answers, so.

**GF:** Brilliant. So, so that's, it is indeed 51%. And, and had you told me we could have done that in nine years, I, I would've, I would've, I would've ripped your hand off I think with that one, to be quite honest, it was absolutely brilliant. And that's thanks to certifying doctors who have actually put so much effort into it and to the conscientious team whereas I say we've adopted this educational supportive approach. And the final, sorry, penultimate slide, but this just shows, this just shows how we've achieved that and we're still on track for a further incremental improvement that's there. And the last slide, just the contact details that are there. And if you've got any queries, very happy to try and address those. So let me just stop the sharing just now if I can. There we go. I think that's us there, and I would be happy, happy to try and address any questions.

**GW:** No, thank you very much, George. That was a very helpful overview and, and reminder of, of how the, how the system works and what we should be looking out for. So, thank you for that. Yes, and, and I would encourage people, please to put any questions you do have in the, in the question and answer function. And we'll, we've maybe got about 10 minutes or thereabouts now to, to work through some of them. So, start with the first one is in relation to, you, you talked about falls and, and reporting them to the Procurator Fiscal. So, I have a question here as to, is there guidance on the proximity of fall with fracture to death for reporting to the, the PF this, the person sort got a ward, a very frail, multi morbid, elderly patient undergoing rehab following the fracture, neck of femurs and sometimes weeks, months after the fracture? And, and, and how do they gauge who should and shouldn't be referred?

**GF:** Yeah. No, really good question. And, and I, I cannot give you a definitive answer. I think it hangs on the facts of the individual case, as the lawyers would say. However, the sort of thing that the Fiscal is particularly interested in is if it occurs in a care home, and perhaps there may have been a number of falls there, and that doesn't automatically mean that they're doing something wrong, but just to make sure that there are not more widespread concerns about that. We, we've had cases where somebody's been, for example, rendered paraplegic in a road traffic accident and then died several years after the event that's there. And the Fiscal has wanted to have that case referred to them. Now, you'd have hoped it would been investigated at the time, but if, if somebody dies from the complications of that ultimately, again, they would like to do that. And the approach we take is this is not a medical decision. We, we know that in most of these cases, it's not going to proceed to a Fatal Accident Inquiry. And, and indeed there may not be a massive investigation, but we have had instances where the, the, the, the, the Fiscal has sent the police round, and I guess this is the upsetting thing because to get a couple of police officers coming round and, and interviewing staff or, or relatives that are there. But it is something that they want to check out and make sure that there's no criminality. So I'm sorry, I, I, I understand the point that's being made it is a very valid one, but nevertheless I, I think if, if there's been a fall and it features on the MCCD and I've seen a, a, a, a comment from one of the regional Fiscals to say the rule of thumb as they describe it, if, if a fall or trauma features in the certificate, then they would expect that to be reported to them.

**GW:** Okay, thank you for that. And along similar lines in terms of reporting to the Fiscal somebody asking for clarification about plural plaques and reporting to the, the Fiscal. So, should everyone be with plural plaques be reported to and, and is there similarly a duration of plural plaques that are relevant?

**GF:** No, this is a peculiarly Scottish thing with Clydeside Action and the position of the Fiscal, which we've had reaffirmed by them on a number of occasions, and we meet up with them at least twice a year, as well as them attending the DCRS management board meetings, is that if there's a plural plaque, albeit it's the marker rather than the disease itself, they do want those reported. It's so that there's not a missed opportunity for relatives.

**GW:** Okay. Thank you. Thank you for that. A couple of questions that have appeared in the chat. So, just to remind people if they could put them in the question and answer section, that might be easier, but, and a question here about in the hospice setting, can we tick the box in attendance even if we haven't seen the patient, but they've been seen by a colleague in, in that?

**GF:** Well, a, a doctor has been in attendance, so you may not have been personally, but it certainly should have been, shouldn't have been no doctors in attendance. because you've got, you've got somebody there as well that's been, been looking after them.

**GW:** Okay. The next question is, what avenues available if families disagree with the medics regarding the, the cause of death? And, and, and, sorry, there's a few, a few popping up here, and has already convinced that, that there's no further action to be taken, but recent experiences highlight that there aren't anything, avenues to and things like private postmortem access cannot be arranged without court action is what someone's written. So, yeah, I don’t know if you’ve any comments regarding that or.

**GF:** Well, sorry there's a number of things wrapped up there. I, I think the, I think it's always beneficial, and it's not our function really, but it's beneficial to discuss the content of the MCCD with the relatives when you hand that over. And I've, Graham, you've heard me speaking before and you know that I think that's been a missed opportunity that perhaps that, and it's understandable with the pandemic especially that maybe doesn't happen as much as we would like it to do there. That's the opportunity to resolve any concerns that are there and discuss what the content of the certificate is. The first 17 years of my career before I specialised in medical law was a GP and I, I would sit down with my book in those days and I would go through that with the relatives and say, this is what I'm proposing to put here. Do you understand that? Have you any questions that you'd like me to answer just now and, and, and that, that I think if, if there had been, if there had been any worries about how the care had been delivered, it's not our function to look at how the care was administered prior to the demise of the patient. But that is an opportunity for a doctor to say, you know, is there anything here that's troubling you and, and, and hopefully resolve that because usually there is a simple explanation for it. So, I, I, I think, I think that's one thing we can do if you've issued a certificate and then you receive further information afterwards, there is a helpful process set out within the CMO guidance, Chief Medical Officer's guidance, to doctors on, on how you have that changed with National Records. So, if, if additional material becomes available of significance, then you can change an MCCD. It is possible to do that and, and one of the team could help you if that was the case. The other thing you mentioned there was autopsies. And again, this is something that, I mean a, a lot of patients that have concerns about what actually happened to their loved one their hope with it going to the Procurator Fiscal, the, the case is that a, an autopsy will be conducted. But of course, that's not always what happens. And if the Fiscal decides that there's no further proceedings required or that's not necessary, it, it, it is possible to arrange a, a, a, an autopsy privately. It's not cheap and you've got, there's no compunction of one of the university departments to do that and there's no legislative basis to do it, but, but it is possible to do it. And we have known that happen on occasion. I mean, couple of times in the existence of the service we've been aware of, of a, a private autopsy being conducted.

**GW:** Okay. No, thank you for that. We had a question relating to abbreviations and just asking are consultants, GPs, our certifying doctors told not to use abbreviations as this person still sees many, which can cause delays from a registration side. And, and just talking about is it, is it on the completion instructions and how can we remind people,

**GF:** Well, we've got it on that, that, that educational sheet that we provided there, what is acceptable. We've included that on it and you should be able to, I hope, access that okay from this webinar. And again, Scottish Government, our colleagues in the health department there, helpfully did extend that to things like CADASIL and so on that are that are very difficult. And indeed, we'll have a yearly review with them as to whether we've got it quite right or whether we can extend it further. I think there are some conditions increasingly that, as, as medical science extends that we might want to be able to include there as well.

**GW**: Okey-dokey. We've had a couple of questions in, in relation to nurses from this point of view certificates another, so someone's asked, you mentioned about the reviewer can speak to a nurse and not the doctor if they're not available. And, and they're told me when they've been trying to get an amendment through, they thought they could only speak to a, a doctor or someone else involved in the care.

**GF:** Yeah, yeah. We, we've found that particularly helpful in intensive care where, where very much you’re on shift patterns and working pretty flat out all the time. So, I mean, we, we, we can we, we can utilise the knowledge that if there's a nurse that's been in attendance there, we can go through that with them so that, that can make an enormous difference in some of these circumstances. Again, what, what we really want to do is to make sure we have an effective structured review and we get it right as quickly as possible for relatives, but if we cannot, not have any unnecessary delays for either the burial or the cremation to take place.

**GW:** Okay. No, thank you. Thank you for that. And, and kind of leading on from that slightly, but someone's asking that there's some conversation nationally about whether nurses working in advance practice roles could issue MCCDs and, and is this something you're aware of or have any advice regarding or.

**GF:** I, I, I think increasingly we're seeing nurses work in advanced roles, and doing things that were only within the province of registered medical practitioners. I don't think either at a Scotland level or a UK level, there's any suggestion of that. We, we certainly have, and it's worked very effectively, have nurses confirming death now so that there's not an undue delay. I mean, one of the contentious issues and, I mentioned it in that slide where we've got things wrong is the time of death. So, it's, it's not the time that death has been confirmed, it's the time to the best of your knowledge and belief when it's happened. And with things like hospitals at night, there can be an understandable delay in somebody coming round and confirming that life is extinct. So yeah, I mean it's, it, it, it's something that we, we'd want to be as empathetic as we could, in that situation.

**GW:** Yeah, no, thank you for that. Somebody was looking maybe just to get the details of the last slide, just the contact details, we could maybe put them in the, in the chat just having recently started working in Scotland, thought it'd be helpful to have your, the contact details of the, the review service so we could, we could hopefully manage to, to put that in the chat.

**GF:** I, I, and if, if you've got a complicated case, and we see this with, thankfully we don't get so many deaths of children, but with neonatal paediatricians quite often it's a very complicated basis for the death of a child. And, and they, they might phone us in advance to discuss A, whether it needs to go to the Fiscal, the case, or B, what the sequence should be within that.

**GW:** Okay. And, and perhaps the final question, I suppose it's in terms of trying to minimise delays, but, and, and, and, and, in view of a checking process, I suppose, within teams or within the NHS and, and I suppose whether trying to discuss deaths with consultants or senior colleagues and, and sort of linked in with the advanced registration process, I think is often sometimes whether what your thoughts are maybe of discussing causes of death in advance of somebody dying. And, and if we do that, how should we document it or share it within teams?

**GF:** Yes, I, I mean clearly document it with sensitivity, but yeah, we do from, we've had it from your colleagues in hospices particularly where somebody's in an end-of-life pathway and there may be something that could cause upset to the family and just going over that. So yeah, we're happy to discuss that. And I, I, I, I think I, I think just doing it in as open a way with the relatives as possible and, and probably just going back to that conversation I related to you that I had at the start of my career as a GP, if I was going to put something into a certificate, discussing it with the, the relatives, what, what that might constitute.

**GW:** Okay. No, thank you George. I think that's us coming to end of our time and I think we've also hopefully managed to answer all the questions, but if there are any other questions that crop up from people, please, they still need an answer to get in touch with us at the Support Around Death website. So, no, thank you very much, George, again for very interesting talk and there's lots of take-home points for us to go with there. So, thank, thanks again. Just a couple of, wee closing remarks from ourselves. All sort of previous webinars are available on the Support Around Death website, and also details on the events page of, of upcoming events that we do have. And from that side of things, we'd like to highlight our ‘Talking about Bereavement’ podcast that's now available on Spotify, so you can catch up on all six previous episodes there. And, and the most recent episode was Lynn Innes chatting to Amanda Gabor who's one of the Advanced Cancer Nurses on dealing with primarily unknown primary cancers. Just about her experiences supporting patients who, who are dying and, and loved ones with anticipatory grief. We're also pleased to announce, as you can see there, that our annual free virtual conference called ‘Bereavement in the Modern World: Kindness in the Chaos’ will be taking place on, on Tuesday 3rd December. So, we're very pleased to give you a heads up about that. And there will be, opportunity certainly to submit abstracts either for hosting a parallel session, or alternatively, for poster presentations. So, there's, there's details regarding that on the, on the website and registration doesn't fully open yet, but you can email the NES Events team if you wanted to be added to the mailing list and then you'll be notified once registration opens. So, and as always, if you'd like to receive information on bereavement related training resources, please sign up to our newsletter, which is issued quarterly and that would give you all the latest updates from that. So, thanks again George and, and, and wish everybody else a, a happy afternoon.

The film was produced in May 2024 and can be found at <https://www.sad.scot.nhs.uk/> or <https://vimeo.com/946942858>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk) or contact supportarounddeath@nes.scot.nhs.uk

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