Citizen Participation and Public Petitions Committee

1st Meeting, 2022 (Session 6), Wednesday 19 January 2022

PE1894: Permit a medical certificate of cause of death (MCCD) to be independently reviewed

Note by the Clerk

Lodged:	23 August 2021
Petitioner	Kenneth Robertson
Petition summary	Calling on the Scottish Parliament to urge the Scottish Government to change the Certification of Death (Scotland) Act 2011 to permit a medical certificate of cause of death (MCCD) to be independently reviewed by a Medical Reviewer from the Death Certification Review Service, where the case has already been reviewed by the Procurator Fiscal but not by a medical professional expert.
Webpage	https://petitions.parliament.scot/petitions/PE1894

Introduction

1. The Committee last considered this petition at its meeting of 3 November 2021. At that meeting, the Committee agreed to write to the Crown Office and Procurator Fiscal Service and Healthcare Improvement Scotland to seek their views on the petition.

2. A summary of past consideration of the petition and responses to information requests are provided for the Committee's consideration.

Background Information

3. During its consideration of this petition, the Committee received 4 written submissions.

4. In his petition, the petitioner states that Section 4(6)(e) of the Certification of Death (Scotland) Act 2011 provides that an application for review of a medical certificate of cause of death by an interested party is ineligible where the cause of death of the deceased person has been investigated by a Procurator Fiscal.

5. The petitioner further notes that in Scotland, anyone can refer a death to the Procurator Fiscal, however, there is no obligation to investigate. An investigation may also only involve asking the certifying doctor if they are willing to certify the cause of death to the best of their knowledge and belief, which is what is required from a medical practitioner.

6. The petitioner believes that this 'creates a dangerous loophole that could be exploited to cover up sub-standard care'.

Scottish Government Submission

7. The Scottish Government's submission highlights that the Death Certification Review Service (DCRS) was established in 2015 with the aim of improving the equality and accuracy of Medical Certificates of Cause of Death; improving public health information about causes of death in Scotland; and improving clinical governance issues identified during the death certification review process.

8. The DCRS, as part of Healthcare Improvement Scotland, checks the accuracy of approximately 12% of all Medical Certificates of Cause of Death (MCCDs) in Scotland.

9. The submission goes on to state that DCRS also carries out Interested Person Reviews in cases where questions or concerns about the content of an MCCD remain after an individual has spoken to the certifying doctor or if questions/concerns arise at a later stage. The purpose of such a review is to check the accuracy of information contained in the MCCD.

10. The Scottish Government states that the Crown Office and Procurator Fiscal Service (COPFS) is responsible for the investigation of all sudden, unexpected or unexplained deaths in Scotland, noting that in many cases investigated by

COPFS, the MCCD will be provided by a pathologist, who is an independent doctor and specialist in causes of death.

11. The Scottish Government's submission goes on to note that 'given that COPFS is independent and has the responsibility to investigate these cases [of sudden, unexpected or unexplained deaths] it would not be appropriate for DCRS to review MCCDs in cases already investigated by COPFS'.

12. In his response to the Scottish Government's submission, the petitioner suggests that the creation of the DCRS 'introduced a level of independent scrutiny of the cause of death notified by the certifying doctor to improve the quality and accuracy of the Medical Certificate of Cause of Death (MCCD)' and in so doing it helped 'to deter criminal activity and poor medical practice.'

13. He goes on to suggest that COPFS is unable to provide that level of independent scrutiny as the Procurator Fiscal is not medically qualified.

Healthcare Improvement Scotland Submission

14. The Healthcare Improvement Scotland submission confirms that the role of its Death Certification Review Service (DCRS) is to check the 'accuracy of a sample of Medical Certificates of Cause of Death, other than those already scrutinised by the Crown Office and Procurator Fiscal Service and stillbirths'.

15. It goes on to state that the Service reviewed 4.427 cases in the 2020/21 period. Of these cases reviewed, 98.6% were randomised reviews and 1.4% were non-randomised reviews (i.e. as a result of a referral from a family, the National Records of Scotland and registrars of births, deaths and marriages 'where there are concerns that the MCCD is inaccurate or may not have been completed correctly').

16. In addition to this work, Healthcare Improvement Scotland also notes that the Death Certification Review Service has a role in 'providing education, guidance and support to doctors who certify the cause of death,' as well as liaising with 'other persons and bodies with a view to improving the accuracy of these certificates' and that the senior medical reviewer, with input from others, 'has developed national standards for the operation of the system, supported by quality assurance activities such as audits, case discussions and peer review, to ensure consistency in the processes and minimise unnecessary delays due to the scrutiny.'

17. Healthcare Improvement Scotland also states that since the Death Certification Review Service was established in 2015, 'the monthly median percentage of cases (MCCDs) 'not in order' (i.e. where the certifying doctor has made a clinical or administrative error) has reduced from 44% to 24.4%.'

18. Its submission also states that 'the establishment of the DCRS was not intended to alter the independent role of the Procurator Fiscal in Scotland to investigate deaths or the arrangements for reporting deaths to the Procurator Fiscal' and that 'where DCRS considers that a case should have been reported to the Procurator Fiscal in the first place, it should be reported by the certifying doctor after discussion between the DCRS medical reviewer and the certifying doctor.' It also points out that 'medical reviewers may also report cases to the local Procurators Fiscal if there is a suspicion of criminality in Scotland'.

19. Healthcare Improvement Scotland suggests that 'the arrangements currently in place seek to achieve an appropriate separation of the functions of the Death Certification Review Service and the Crown Office and Procurator Fiscal Service, whilst ensuring that the DCRS is able to contribute to improvement in the quality of death certification in Scotland,' noting that in considering the petitioner's asks 'it will be important to reflect on risks in relation to potentially contradictory conclusions arising from any review process and the impact that would have on public confidence'.

Submission from the Lord Advocate

20. In her submission, the Lord Advocate states that 'as the head of the systems of criminal prosecution and the investigation of deaths in Scotland, I have responsibility for the investigation of all sudden, suspicious and unexplained deaths' and that any decisions taken 'in my capacity as Lord Advocate must be taken independently of any other person'.

21. The Lord Advocate goes on to note that 'whilst it is correct to say that Procurators Fiscal are not medically qualified, any decision to permit a MCCD to be issued would only be taken following discussions with a medical practitioner' and that whilst this would 'ordinarily be the reporting doctor,' it may also include discussions with 'other doctors involved in the care and treatment of the deceased if they deem that to be necessary'.

22. Whilst the Procurator Fiscal in each case will take into account and discuss any concerns expressed by the nearest relatives, 'they are not obliged to instruct that a post mortem examination take place even if one is sought by next of kin'.

23. The Lord Advocate also says that, in establishing what should be stated on an MCCD, the Procurator Fiscal 'may seek an independent medical opinion, for example from a pathologist, for their view on the appropriate MCCD or whether anything would be gained from conducting a post-mortem examination'.

24. The Lord Advocate points out that 'in relation to non-criminal deaths, the certifying medical practitioner is required to certify the MCCD to the best of their knowledge and belief,' noting that 'absolute certainty is not required'.

25. Where the nearest relative disagrees with the conclusion of the Procurator Fiscal about the MCCD and wishes a post-mortem to take place, then the Lord Advocate suggests that 'it is open to the nearest relative to discuss the possibility of a hospital post mortem taking place' or alternatively 'the relative can arrange (and meet the costs of) a private post mortem'.

26. The Lord Advocate concludes by suggesting 'it would not be appropriate for DCRS to review MCCDs in cases already investigated by Procurators Fiscal'.

Action

The Committee is invited to consider what action it wishes to take.

Clerk to the Committee

Annexe

The following submissions are circulated with consideration of the petition at this meeting:

- **PE1894/C: Lord Advocate submission of 30 November 2021**
  PE1894/D: Healthcare Improvement Scotland submission of 10 December 2021